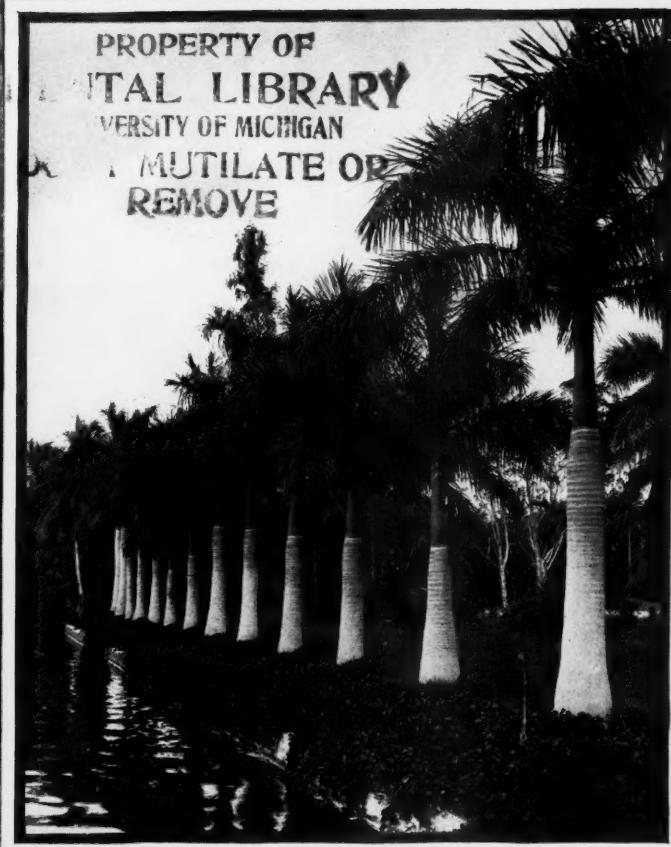


# THE DENTAL DIGEST



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FEBRUARY - 1926

VOL. XXXII, No. 2

EDITED BY  
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PUBLISHED BY  
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220 WEST 42<sup>nd</sup> ST. NEW YORK.

# HARDENED

BY

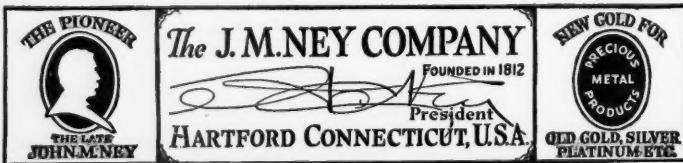
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3. Orthodontia appliances or other uninvested work should be placed in a matrix of soft investment before proceeding as above. One-piece castings should be heat-treated immediately after casting and before being removed from the flask or ring.
4. Pickle the work cold or by boiling in acid. (When heated to redness and plunged in acid or water, these alloys are annealed or softened.)

*What golds does your laboratory use?*



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# THE DENTAL DIGEST

GEORGE WOOD CLAPP, D.D.S., EDITOR

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## OUR COVER THIS MONTH

Florida was discovered by a Spanish explorer named Ponce de Leon, who set out from Spain to find the Fountain of Eternal Youth. He named the place Florida, because of the great exuberance of flowers which he saw on his arrival. Topographically the State is a great stretch of flatlands, there being no land elevation more than 300 feet above sea level. Forests are estimated to occupy 27,000,000 acres, showing 203 varieties of wood, including 281 native and cultivated trees.

Our COVER PICTURE shows a row of Royal Palm Trees, which to a stranger look like things artificially fixed up for ornamental purposes. But that's the exact way they grow, and remain very beautiful objects throughout the year.

A Federal report says that Florida's warm climate, dry winters and medicinal springs have combined to make it the Riviera of America. Among its many health resorts this report mentions St. Augustine, Orlando, Palm Beach, Miami, Orlando and St. Petersburg. And what changes the whole life-time brings about! No far back than 1869 Alabama offered one million dollars for Florida to annex it to its own territory, but Congress delayed action in considering it and the matter was dropped. Today you would have to pay that sum of money for a good corner lot in Miami.

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# THE DENTAL DIGEST

Vol. XXXII

FEBRUARY, 1926

No. 2

## Occlusion—The Fundamental Element in Dental Science\*

By Paul R. Stillman, D.D.S., F.A.C.D., F.A.A.P., New York, N. Y.

The assertion implied in the title of this paper should need neither defense nor explanation, yet when I have presented my views as to how profoundly occlusion influences the health of the entire dental mechanism, you may feel that some defense of these ideas will be in order.

The first studies of occlusion were made by the prosthodontist, or rather the dentist, in his frequent capacity as a restorer of teeth for the edentulous. When the first "plates" were made, they had to satisfy two requirements—they had to perform the function of mastication and they had to "stay in place" with comfort during this process. The earlier dentist found that while he might make artificial teeth which would have occlusal contact, this did not necessarily provide function and stability. He early focused his attention upon the manner in which his artificial teeth "hit" upon each other and recognized the necessity for a definite relationship of each tooth to all others, in order to provide for their greatest usefulness.

Until very recent years the study of the mechanics of occlusion has remained in the hands of those doing full denture prosthesis. Even the orthodontist began his work with a primary view of improving the appearance of his patients. In fact, it may be said that the studies of occlusion which orthodontists have made, even in recent years, have for their basis the improvement of the dento-facial relations rather than the development of function. About ten years ago, when the periodontist began to study and increase his knowledge in the field of periodontal disease, he found that his efforts in treatment began to revolve to a large extent around the problem of occlusion. Where the prosthodontist found that instability of his dentures was related to faulty occlusion, the periodontist found that the cause of instability of the natural teeth was due to exactly the same kind of mechanical discrepancy.

\* This paper was read before the following societies: The Dental Forum, Milwaukee, Wis.; The St. Paul Dental Society, St. Paul, Minn.; The Minneapolis District Dental Society, Minneapolis, Minn.; The G. V. Black Dental Club, Des Moines, Iowa; The Duluth Dental Society, Duluth, Minn. It was printed, without illustrations, in *The Minneapolis District Dental Journal*.

The periodontist began his ministrations by operating on the various affected teeth as individuals and with his attention focused on a disease process occurring in vascular tissues. He looked upon the periodontium as the locus of a pathologic process having but slight relationship to anything mechanical. At the present time periodontists are focusing their attention on the mechano-anatomic factor in occlusion, which has become widely recognized as dominating the pathological picture.

I wish to present a conception of the teeth and their supporting structures, including the jaws and temporomandibular joint, as comprising a highly developed and delicately adjusted mechanism. I do not wish you to forget, nor shall I forget, that this mechanism is made up in large part of vascular tissues, subject to nutritional and other disturbances, but I do wish to impress upon you that which I believe to be a fact, viz., that the health of the structures which comprise this mechanism is primarily linked up with the mechanical coordination and harmony of the occlusion; also, that just as the automobile, for instance, requires the harmonious adjustment of all its parts for continued economical functioning, so does the human dental mechanism require harmonious adjustment in order that it may perform its functions without injury to itself. The point I wish to make is that the teeth and jaws are a mechanism, subject to the laws governing all mechanical things, differing from a man-created machine chiefly in the marvelous fact that the former is composed of living tissue cells and powers of self-regeneration while the man-made mechanism is not.

It is very easy for us to confuse self-regeneration, a power inherent in the living organism, with self-adjustment, a faculty possessed by the dento-alveolar mechanism in only a minor degree. In other words, adjustment of mechanical incoordination of the teeth, through the attrition of occluding tooth surfaces, occurs less successfully than casual observation would lead us to expect.

Perhaps it will be advantageous to follow the analogy of the machine a little farther. We know that the gears and other moving parts of the automobile must be perfectly formed and correctly assembled in order that they may function without doing injury to themselves or to the rest of the apparatus. We know also that wear of moving parts is inevitable in all mechanisms, and that this wear, when it occurs, requires a compensating adjustment of all physically related parts. My observation has been that whenever we find patent deformity of the occlusal surfaces through wear, there is usually found a concomitant disbalance in function. This is a very important point.

We see in nearly all mouths, especially in those having a minimum of artificial restorations, evidences of more or less wearing away of the occluding surfaces through their contact with each other. It is but natural to assume that mechanical incoordination of these surfaces

would be adjusted perfectly and universally by this same process which produced the deformity. This is, however, far from being the case. Due to the yielding character of the periodontium, even though very slight in extent, natural self-adjustment is seldom carried to that point of perfection requisite for the attainment of adequate occlusal balance.

When a lack of occlusal harmony exists from the time of the eruption of the teeth, it frequently happens that an abnormal occlusal habit will be developed. Under such circumstances tooth-deforming attrition of the opposing surfaces will take place, but the tendency is usually toward an exaggeration of the occlusal deformity, a condition which throws the dental mechanism still further out of functional balance. Here we recognize a failure of nature to reduce an occlusal deformity through normal mechanical wear, a condition which should apparently make for self-adjustment.

When periodontists began to study occlusal relationships from the standpoint of their bearing on the health of the periodontium, they soon came to recognize a distinction in occlusal adjustment more delicate than had previously been conceived to be required. Teeth whose occlusal relations, as measured by the eye, were perfect were found to be in a state of traumatic occlusion when judged by the criterion of periodontal health. Moreover, when adjustments were made which might be so slight as not to be discernible to the eye, the sharp improvement in the health of the supporting tissues was so marked as to compel the realization of the extreme delicacy of the mechanical relationships involved. I wish to pay tribute here to the work of the prosthodontist and the orthodontist in the problems of occlusion. At the same time I believe that the work of the periodontist will result in a refinement of our knowledge on this subject which will be of immense value in all branches of dentistry.

So far I have taken for granted the general acceptance of the postulate that traumatic occlusion is the most important factor in the etiology of most cases of periodontoclasia, nor shall I take up your time with an effort to justify this theory. It is, however, requisite that a few words be given on the relationship of this factor to various pathologic disorders in the mouth. When there is a lack of balance in the occlusal relationships of the teeth, whether natural or artificial, certain teeth receive an occlusal stress in excess of that which nature and the laws of mechanics decree. This produces, in the course of time, an irritation of the entire periodontium, which may manifest itself in either vascular or neural disturbances, or both. Through this disbalance of physiologic equilibrium, local nutrition is interfered with and infection is induced. It is for this reason that I have stressed so consistently the thought of the dental mechanism as an apparatus, together with the requirements of harmonious adjustment of its moving parts.

I would not have it thought that I desire dentistry to become more mechanical than it has been—nor, on the other hand, would I have it less so. Agreeing as I heartily do with the present trend toward a more adequate training in science for the dentist, I nevertheless wish to keep in your mind the thought that while dentistry has as its chief concern the diseases occurring in living tissues, it is practiced largely through the medium of mechanical operations. It has been my observation that as dentists give more attention to the allied medico-theoretical aspects of their work—those so-called scientific branches—they tend to become less adept in the application of technical measures for the treatment of the diseases which they have been studying. *What dentistry needs for its development is not more science and less mechanics, but more science and better mechanics.* These thoughts could not be more clearly expressed than in an editorial which appeared in *The Dental Cosmos*, September, 1924:

“Dentistry has taken its proper place as a biologic science, and its mechanical procedures are now viewed in the light of engineering problems definitely related to the biologic field. It is this recognition of the importance of the biologic factor in dental practice that constitutes the greatest advancement of present-day dentistry, an advance which may be counted as a direct and immediate result of the recognized and advanced dental educational curriculum.”

Assuming that the theory of physiologic or so-called balanced occlusion as being of primary importance in periodontal disease is acceptable, we now come to its application. The questions which should be of interest at this point are:

1. How shall we determine whether a given occlusion is physiologic or pathogenic?
2. Is it necessary that visible disease be present to confirm a diagnosis of traumatic occlusion?
3. On what shall a choice of a method of treatment be based?
4. How shall we determine when the traumatic occlusion has been entirely relieved?
5. How may we determine whether a corrected traumatic occlusion has recurred?

Let us discuss these questions in sequence:

#### HOW SHALL WE DETERMINE WHETHER A GIVEN OCCLUSION IS PHYSIOLOGIC OR PATHOGENIC?

This question implies the consideration of a mouth in which there is no visible evidence of disease. It should first be made clear that an occlusal relation may exist which may be designated as a traumatic occlusion, but which has not, at the time of observation, produced visible tissue injury. It is termed at such a period a potential traum-

matic occlusion—a condition which if left uncorrected will ultimately produce actual injury. Whether we are to attempt its correction at the time it is observed is beside the mark. The important thing is to note the condition and take suitable precautions against subsequent development of disease.

As a result of my studies in this field, I have come to recognize certain characteristics of the teeth and of their arrangement in the arches as constituting a potential source of injury. I would first call attention to teeth having long sharp cusps and deep sulci. No matter how perfect the occlusion of such teeth may be, their occurrence in the modern undeveloped jaw spells most inevitable future damage to the supporting tissues. The close interlocking of such teeth causes tremendous lateral leverage against their supporting structures when the jaws are used in eccentric occlusion. Moreover, in such a mouth the full exercise of the function of the teeth and jaws is inhibited. The periodontium thus fails to attain its fullest development. And deficient blood supply, lowered resistance and disease developed through tissue disuse are the natural sequelae.

Were jaws having locked cusps, such as I have described, found in a state of normal orthodontic occlusal relation, harm would still follow. It has been my observation that this class is almost invariably associated with a condition of occlusal disbalance, which produces individual traumatisms here and there about the mouth. At any rate, they are always to be looked upon as a source of danger. On the other hand, such cases are commonly very pleasing to the eye and not infrequently are affirmed by the orthodontist as representing an ideal occlusion. They may be claimed to be orthodontically correct, yet found functionally incapacitated, at least to some degree. Such a dental mechanism is actually defective in regard to occlusal balance.

We have so far been speaking of teeth whose occlusal arrangement was within the bounds of what is actually classified as "normal" occlusion. We now consider those cases in which some degree of malocclusion exists. The most common instance is that in which the overbite of the anterior teeth is out of harmony with the curve of Spee. In these cases, when the mandible is protruded, the jaw rides forward on the lingual surfaces of the upper incisors in contact with the labial of the lower, these teeth receiving thereby the entire force exerted by the muscles concerned in this movement. In such cases the element of trauma is frequently to be detected at a very early age; even where the overbite is apparently slight, it will frequently be found that the upper and lower incisors are in contact in the protruded position of centric occlusion, while the posterior teeth are widely disoccluded. This does not necessarily constitute a traumatic occlusion. It has been my observation, however, that periodontiasis follows in the majority of cases.

It is, of course, a fact that in a fair percentage of such cases as I have just described the opportunity for occlusal function is present. Under such circumstances it might be possible that through the agency of wear of the occluding surfaces a potential traumatic occlusion could be corrected by the means which nature has provided, viz., a so-called mechanical "wearing in" of the occluding teeth.

We now come to those cases in which the probability of the existence of traumatic occlusion is more obvious, i. e., cases exhibiting definite malocclusion. (The term "malocclusion" is here used in the orthodontic sense.) It is in such cases that the vast majority of periodontal lesions develop.

We must here make the distinction between malocclusion and traumatic occlusion. The terms are not synonymous, although they have frequently been thus employed. I have seen many cases exhibiting pronounced malocclusion in which there was no perceptible interference with occlusal coordination. Such cases do not necessarily develop periodontal disease. They must, of course, be regarded as having a potential traumatic occlusion on account of probable deformity occurring as the result of functional misuse; but, in the absence of visible evidence of periodontal disease, there is seldom demand for adjustment from the standpoint of the prevention of disease.

The malocclusions to which I have referred are so numerous and occur in so many combinations that an attempt at enumeration is impractical. Let me only caution you not to disregard slight malpositions of the individual teeth or of the arches as a whole. Often a slight torsion of a single molar will produce a profound disbalance—to cite but one example, which is undoubtedly familiar to every dentist. When we add to the various malocclusions of the natural teeth the professionally produced malrelationships induced by poorly balanced and incorrectly formed restorations, we have summed up the more common types that make for occlusal conditions which will probably result in periodontal disease.

52 Vanderbilt Avenue.

*(To be continued)*



## Orthodontia for Adults

By Raphael J. Moolten, D.D.S., New York, N. Y.

Many dentists are doing a serious injustice to adults who suffer socially, commercially or personally because of irregularities of the teeth, when they tell such patients that the condition cannot be corrected because of the patient's age. For twenty-five years I have been engaged in the correction of irregularities of the teeth. About 40 per cent of my patients are adults from 26 to 58 years of age. In spite of the generally accepted statements to the contrary, I do not find it particularly difficult to re-align the teeth for such patients without causing death of the pulp, discoloration of the teeth, periodontoclasia or antrum or sinus troubles.

In all cases where orthodontic interference is advisable, it should be undertaken at a very early age, when that is possible. But there are many adults for whom such service was not rendered in childhood, perhaps because of lack of funds or failure of the parents to appreciate the importance of correction or because the family dentist advised delay. Children do not grow out of conditions which justify orthodontic interference.

It is hardly possible to overestimate the importance of a pleasing appearance to a great number of adults from social, professional, commercial or personal point of view. If it is within our power, as dentists, to restore a personal appearance which will enable someone to keep a desirable position or to enjoy social relations or the satisfaction which comes from appearing well, it is a professional duty either to restore the appearance or, if we do not care to undertake the work ourselves, to refer such persons to someone who can render the necessary service.

For reasons which are generally well understood, correction of the relations of the dental arches is very important to health, especially to the protection of the pulmonary passages. The correction is important from the point of view of mastication because the efforts to masticate made by many adults with malposed teeth or deformed jaws increase the malposition and the deformity. Such mastication, even if satisfactory to the patient, is recognized by dentists as so inefficient as to permit serious impairment of the health. For many patients the teeth can be arranged in such way that the masticating efficiency will be greatly increased and the general systemic resistance will be raised.

The appliances for this work are similar in character to those used for children. For more than a majority of cases removable appliances are preferable to the fixed variety, because the adults realize the importance of the correction and are more faithful in wearing appliances, and because more pressure can be applied to the adults than to chil-

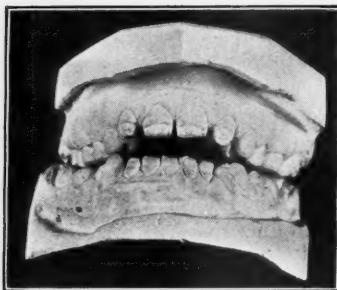
dren. It is desirable that the orthodontist should keep cases under careful observation lest an occasional patient should attempt to adjust the appliance to get more action.

The principal elements in successful orthodontia for adults are caution, common sense and practical experience on the part of the dentist. The appliances are of secondary consideration. The dentist who is to undertake the work should thoroughly familiarize himself with the details of the case by careful questioning of the patient. He should learn whether or not the case is specific and, if it is, whether it is congenital or acquired. He must ascertain whether there is any antrum or sinus trouble or a fracture or a dislocation or any other systemic disturbance. The answers to these questions and the results of his own observation are necessary in order to enable him to judge what appliance to use and what degree of force he may apply so as to do satisfactory work with little or no disturbance of the affected parts.

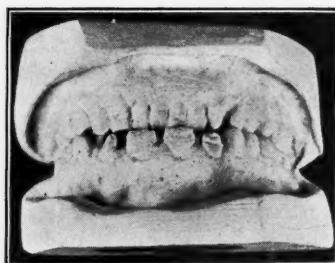
It is difficult to get satisfactory models of completed cases because, when the correction is satisfactory to the patients, they frequently secure positions in other parts of the country or move away. Sometimes it is because they are so busy that it is difficult to get them at a time when one can take impressions.

#### A FEW OF THE PRACTICAL CASES SHOWN

*Case No. 1.* Miss F. D., aged 28, expert accountant. She was embarrassed in business through her inability to speak so that she could be readily understood and she seriously considered giving up a very desirable position. In early life she suffered from rickets. Radiograms



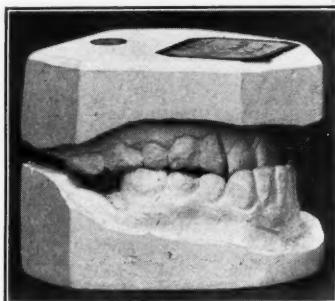
Case No. 1  
As it presented, Oct. 26, 1920



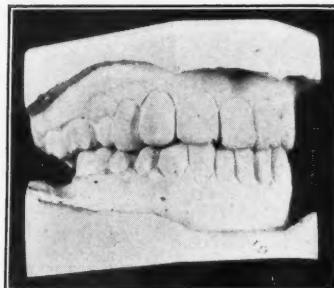
Case No. 1  
After treatment for 8 months

did not reveal the presence of permanent canines. She had been repeatedly advised by dentists that because of her age nothing could be done to correct the condition. In less than a year the articulation was corrected in such a way that she could speak well and her embarrassment was removed.

*Case No. 2.* Miss F. M., aged 30. This case was corrected during part of 1915 and part of 1916. There was marked mandibular prognathism. This lady occupied a responsible position and was embarrassed by the criticisms of her fellow workers, who called her "bulldog." Dentists advised that because of her age it was impossible to



Case No. 2  
As it presented

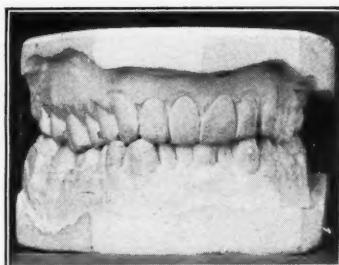


Case No. 2  
At about the time of completion

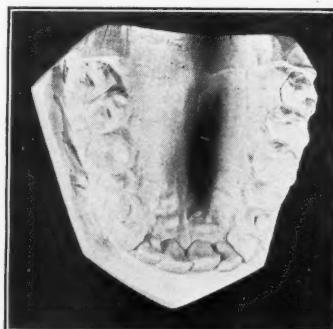
remedy the condition. After six months of treatment the uppers closed outside the lowers in the normal manner. In nine years there is no indication of the return of the former condition, and no complaints by the patient. The lady is now married and happy.

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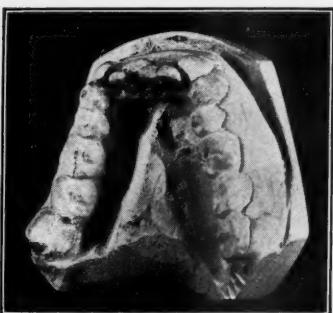
*Case No. 3.* Mr. V. S., treated from August, 1919, to October, 1921. He was a screen star, aged 37, when he presented. The upper centrals, especially the right, were a little back of the line of the normal arch. When his teeth were exposed in making a picture, the shadow



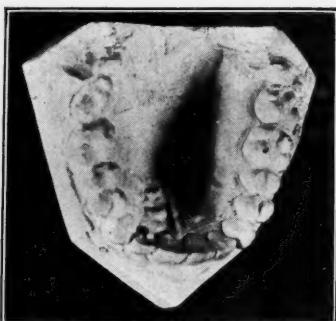
Case No. 3  
As it presented, August 6, 1919



Case No. 3  
The uppers before treatment



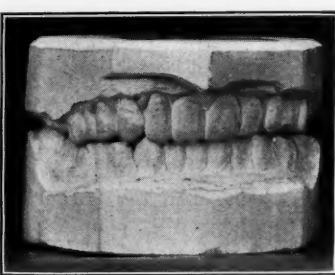
Case No. 3  
The lowers before treatment



Case No. 3  
The uppers after treatment



Case No. 3  
The lowers after treatment

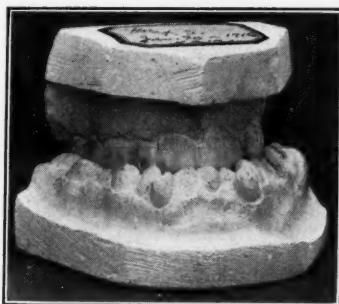


Case No. 3  
Final occlusion, Oct. 1, 1921

made it appear as if there were no upper centrals present. He was compelled to put wax on the teeth to restore the contour. The bunched arrangement of the lower anteriors was embarrassing to him, especially when magnified thirteen times on the screen.

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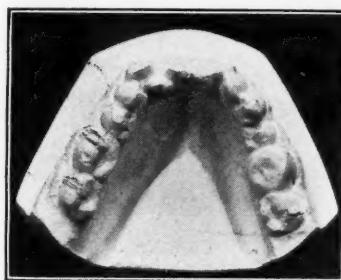
*Case No. 4.* Miss F. S., aged 24, graduate nurse. Treated from February 4, 1916, to March, 1918. The upper arch was very small, partly because of lack of development and partly because of early extraction of some of the teeth. This lady suffered in the practice of her profession because patients formed an aversion to her appearance. She never received any encouragement from dentists that the condition could be corrected. In about two years the condition was corrected as shown by the illustrations.



Case No. 4  
As it presented



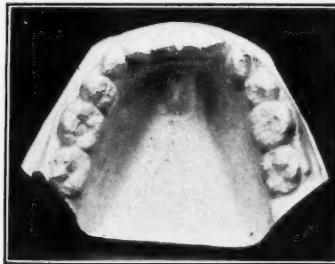
Case No. 4  
The uppers before treatment



Case No. 4  
The lowers before treatment



Case No. 4  
The uppers after treatment



Case No. 4  
The lowers after treatment



Case No. 4  
Final occlusion

*Case No. 5.* Treated from September, 1919, to March, 1921. The patient was a lady, aged 36, who was a professional singer. She found great difficulty in securing the kind of engagements to which her ability entitled her because of the appearance caused by the superior protrusion. When treatment had been going on for less than a year, she secured a very desirable engagement. She had applied to several dentists for relief but without success because of her age.

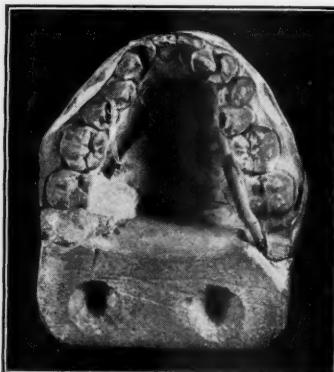
The history of Case No. 5 is told in the following six illustrations.



Case No. 5  
As it presented, Sept. 22, 1919



Case No. 5  
The uppers before treatment



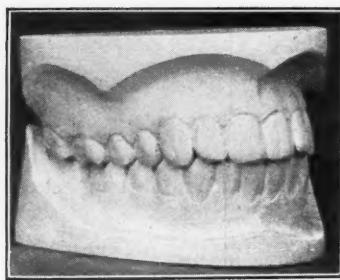
Case No. 5  
The lowers before treatment



Case No. 5  
The uppers after treatment



Case No. 5  
The lowers after treatment



Case No. 5  
Final occlusion, March 19, 1921

35 West 42nd Street.



## An Appliance for Securing Bilateral Expansion of the Dental Arch\*

By Percy Norman Williams, D.D.S., New York, N. Y.

There are two classes of movement that are generally agreed upon as necessary in nearly all cases, expansion and adjustment of the individual teeth. It does not necessarily follow that these movements must be simultaneous; in fact, in the majority of cases showing marked arrested growth expansion should precede alignment of the individual teeth. An ideal appliance is one capable of accomplishing these movements. In addition to this it must exert pressure which conforms as nearly as possible to natural tooth movements. It must be as nearly free as possible from having a detrimental effect upon the enamel. It should be as inconspicuous as possible, although this should not be sacrificed for other desirable qualities. As recently as fifteen or eighteen years ago the labial expansion arch met the first two conditions but was lacking in the others. It is possible, of course, to accomplish expansion and alignment of the individual teeth with an 18-gauge arch wire, but it has some drawbacks, such as the necessity of using ligatures, its lack of stability and its uncleanliness, and, it might be added, its clumsiness. Many of these undesirable qualities have been eliminated by the introduction of the ribbon arch and the 22-gauge round wire, as suggested by Hawley.

With the introduction of the lingual arch wire we have added to the struggle for the ideal appliance one which is capable of expansion and considerable adjustment of the individual teeth, but, in my opinion, it does not and can not take the place of the labial arch wire. It would seem that at present the ideal appliance is made up of a combination of the small resilient labial wire, attached to the anterior teeth by means of bracket bands, and a lingual wire for expansion. It is probably true, as the exponents of the ribbon arch claim, that they can accomplish all movements with that appliance, while the followers of the lingual type are just as enthusiastic about the latter appliance. With the introduction of a new appliance we should be careful that we, in our enthusiasm, do not become slaves to a single type, when such an appliance is limited in its action. A plan must be conceived before it can be executed, therefore before an appliance can be selected some definite, clear-cut design must be present in the mind of the operator. The movements necessary should be analyzed and the appliance selected that will best accomplish the desired results.

In bilateral expansion an appliance should be so constructed as to

\* From a clinic given before the First District Dental Society, December, 1925.

be firmly retained with freedom from interference by mastication, the tongue and other soft tissues. It should possess sufficient resiliency to move the teeth, but should be free from exerting a harsh and rapid movement. When desirable, it should move the teeth, as nearly as possible, bodily, i. e., without tipping or rotation. Its action should be positive and definite and it should be capable of adjustment without danger of distortion. In fact, uncertainty or guesswork should be entirely eliminated. It seems unnecessary to state that it should not be so delicate and complicated that its adjustment can be accomplished by but a limited few, but it should be capable of adjustment by anyone possessing an average degree of technical skill. It should be applicable to temporary as well as mixed and permanent arches, and it should not interfere with the molar drift.

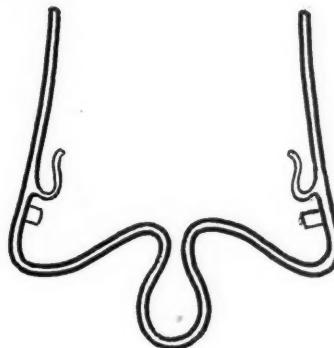


Fig. 1  
Appliance for bilateral expansion

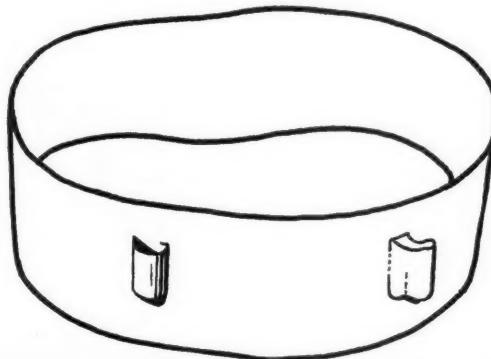


Fig. 2  
Showing half-round tube and locking lug on molar band

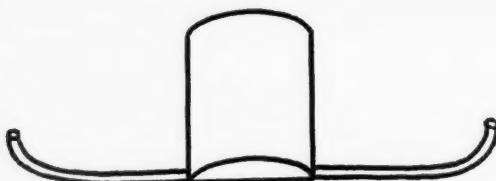


Fig. 3

Half-round wire with spurs to be inserted in molar tubes before taking plaster impression

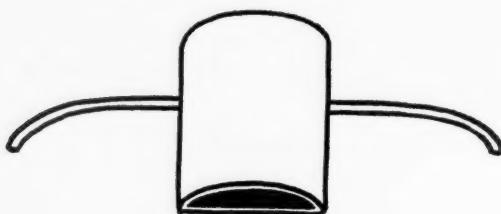


Fig. 4

Tubes with spurs to be placed on half-round pins before pouring stone model

In Figure 1 is shown an appliance for accomplishing bilateral expansion. It is the result of seven years' effort to develop the type of appliance herein described. It is inserted as follows. Half-round tubes and lugs are placed on the inside of the molar bands, which are cemented on the first permanent molars. (Fig. 2.) Half-round pins with wire spurs attached, such as shown in Figure 3, are inserted in the half-round tubes in the mouth and a plaster impression taken. When the impression is removed, the spurs of the half-round pins are embedded firmly in the plaster. Before the cast is poured, half-round tubes with the wire spurs attached (Figure 4) are placed over the pins which are embedded in the plaster and a stone model is now cast in the impression. After it becomes thoroughly hardened, the impression is removed and the half-round tubes are in the same relation to the cast as the half-round tubes are to the teeth in the mouth. On this stone model is constructed an appliance such as shown in Figure 1. The appliance is inserted in the mouth and locked to the lingual surfaces of the molars. When pressure is desired, the appliance is removed and placed in an instrument which I have designed for producing a definite amount of expansion without distortion (Fig. 5). The appliance is replaced in the mouth and locked. The entire operation requires about seven minutes.



Fig. 5

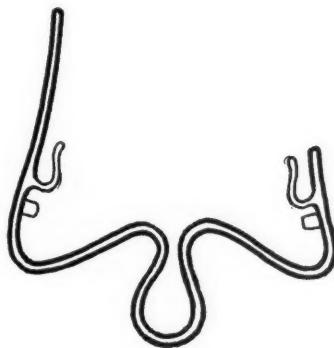


Fig. 6

Appliance for unilateral expansion

For unilateral expansion the appliance shown in Figure 6 is used. One tooth at a time is moved in order to avoid disturbing the stationary anchorage on the opposite side. This appliance will act over a period of from six to eight weeks without readjustment and will remain in-

definitely as a working retainer. It is comfortable and does not interfere in the slightest degree with speech.

You will perhaps have observed by now that it is my belief that we have not devised an appliance which is equally satisfactory for expansion and adjustment of the individual teeth. The appliance described above is used for expansion purposes only, but its operation is simultaneous with another appliance which is used for adjustment of the anterior teeth.

40 East 41st Street.

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## Some Essentials in Constructing Full Upper and Lower Dentures\*

By S. J. Scheckter, D.D.S., New York, N. Y.

### CLASSIFICATION OF TISSUES

The first step toward the construction of successful dentures is a classification of the tissue conditions in edentulous mouths. The classification offered by S. G. Supplee has been very satisfactory. For upper cases it is as follows:

Class 1. Firm ridges covered with a uniform layer of slightly yielding membrane. Buccal and labial attachments connected high on border of ridge.

Class 2. Firm ridges and vault covered with tensely drawn membrane. Very small area of soft tissue over the rear third of the hard palate on either side of the median line. Buccal and labial attachments are connected close to the crest of the ridge and very definite in movement.

Class 3. Firm ridges. Soft area in the vault, particularly over the rear third of the hard palate on either side of the median line. The buccal and labial attachments are connected to the ridge areas of movable soft tissue overlying the buccal and labial surfaces. Small bony prominences are often hidden under the soft membrane and cannot be detected and properly located without pressure by a ball-end instrument.

Class 4. High or low vault. Soft ridges or tuberosities. Buccal and labial attachments either high or low. Vault either hard or varying in density.

For lowers the classification is as follows:

Class 1. The prominent ridge that is hard all over.

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\* From a clinic given before the First District Dental Society, New York, December, 1925.

Class 2. The flat, hard ridge with prominent muscles, whose bases of attachment are at least one-quarter inch from the crest of the ridge in the molar region.

Class 3. The flat or high ridge where the muscular attachments are movable to the crest of the ridge, particularly in the molar region. (In many cases this type has indirect attachment to the top of the ridge through areas of movable soft tissue.)

Class 4. The flexible or soft ridge. Muscular attachments either direct or indirect through soft tissue.

#### STUDY MODELS AND SPECIAL TRAYS

Study models of both jaws should be made and special impression trays shaped over them. For the uppers I take a snap impression, with modeling compound, in large trays which have been made especially for me from thin metal. For lower impressions I use a full lower impression tray, No. 4 or No. 3. This impression also is taken in compound. Plaster or stone models are poured in both impressions. When the models are hard, I swage over them trays of the same metal as in the special upper trays or of some other satisfactory impression tray metal. Both trays are trimmed to the outlines which I have already traced on the study models.

At the next sitting both trays are tried in the mouth and refitted in such way that they will not impinge upon the muscle attachments. It is often necessary to shorten a tray, especially a lower. I consider that a tray fits well when it covers as much of the ridge as may be without the patient's being able to lift it from the ridge with any movement of the cheeks or tongue.

#### UPPER IMPRESSION IN COMPOUND

The upper impressions are taken in modeling compound which has been heated to  $150^{\circ}$ - $160^{\circ}$ . One cake of compound is enough to start with, in ordinary cases. The impression surface of the compound is heated over the alcohol flame until it is glossy, but it must not be burnt. Temper in water which is from  $150^{\circ}$ - $160^{\circ}$ , introduce it into the mouth and hold it firmly in position. See that the saliva ejector is in the mouth and chill the impression with cold water. It is important that the impression should not be removed until it is thoroughly chilled. At this stage the impression should manifest considerable suction. If it does not, something is wrong with the initial steps and it will be well to begin again at the beginning. Trim the excess compound wherever necessary.

#### MUSCLE-TRIMMING THE UPPER

When muscle-trimming the upper, heat the buccal wall from the

heel to the cupid on one side over an alcohol flame, until the surface of the compound is glossy. Temper it in hot water, place it in the mouth, have the patient open and close the mouth, and massage the cheek with the fingers to adapt the compound to the buccal wall. Chill thoroughly and remove. Muscle-trim the other side in the same way. For the anterior section of the impression, muscle-trim from the cupid to the central on one side and then from the cupid to the central on the other side.

#### ESTABLISHING RELIEF

It is desirable to establish relief in certain areas. With an indelible pencil, mark a circle around the areas in the mouth where it is desired to make relief, especially the hard areas upon which the plate would rest and tilt. Wet the impression, place it in the mouth and transfer the marks to the impression. With a scraper or knife, scrape away the compound inside the marks, as may be desired. Try the impression in the mouth and repeat the technic until the patient is unable to dislodge the impression by movements of the cheeks and lip.

#### POSTDAMMING

Examine the posterior part of the vault to observe how much yielding tissue is present. If there is considerable yielding tissue, add enough soft carding wax (the wax on which artificial teeth are carded) to permit adaptation. Soften the surface of the wax a very little over a small alcohol flame, insert the impression and press to place. If the tissues are hard at the posterior part of the vault, less wax will be needed. An excess of postdamming will spoil the suction, because the denture will not go up to place. As a check on the success of the postdamming, press the impression up to place and watch the posterior margin with a mouth mirror. Watch when the bubbles are forced out and add a little wax wherever this happens. Add wax and repeat the pressure until the seal is perfect.

#### LOWER IMPRESSION IN COMPOUND

To take the lower impression, soften compound to about  $150^{\circ}$ - $160^{\circ}$ , form it into a roll about the size of a compound tracing stick and place it in the special tray which was shaped over the study model. Before placing the compound, heat the tray a little over a flame. Glaze the impression surface as was done with the upper, temper in water and place in the mouth. Face the patient and hold the impression steady by placing both thumbs under the chin and two fingers of each hand on the upper surface of the tray in the bicuspid region. Chill thoroughly and remove.

#### MUSCLE TRIMMING THE LOWER

Muscle-trim the lower impression from heel to cupid on the lingual

side first, adding or cutting away compound as the case requires. To do this, soften the margin in the flame of the alcohol lamp, temper it in hot water, place the impression in the mouth and cause the patient to project the tongue from the mouth toward the opposite side of the mouth. Soften the buccal margin of the same side from heel to cupid, place the impression in the mouth, have the patient open and close, and massage the cheek to get the compound close to the ridge. Trim the other side of the impression in the same manner. Muscle-trim the lingual margin from cupid to cupid by softening it and causing the patient to project the tongue. To trim the labial margin, soften the compound from cupid to central on one side, place in position and have the patient raise the lower lip. Massage the soft compound through the lip. Do the same on the other side.

When these steps have been properly carried out, the impression will have suction when in position and the patient will be unable to break that suction by the movement of the lips, cheeks or tongue. Box the impressions with carding wax, which can be purchased in strips of the proper width. Pour stone models.

Make baseplates with a satisfactory baseplate composition. Build wax rims with a suitable set-up wax.

#### TAKING A CORRECT BITE

When taking the bite, I am careful not to say anything to the patient about biting. I lower the headrest of the chair until the patient's head is tipped well back and, with the baseplates and rims in position, tell the patient to close. If I see that he is nervous and is making an effort that might lead him to close anteriorly, I say nothing but merely keep the headrest in the same position and cause him to repeat the closing movement until the nervousness disappears and he relaxes. He will then close in what is to him a comfortable position. It is very difficult for patients to bite forward when the head is in this position, and this technic has proved uniformly satisfactory in my hands.

I use an instrument which indicates the face form as an aid in determining the forms of the upper centrals for the case, and I set the teeth to establish anatomical articulation for that case. After the case has been completed and tried in, I grind the teeth with an abrasive until they clear in all the movements of protrusive and lateral articulation.

507 Fifth Avenue.



## Developing of Dental Films

By Joel M. Zametkin, D.D.S., Brooklyn, N. Y.

*(Continued from January)*

A developed film appears to have a yellow-gray and a black-gray mottled effect. The yellow is a silver bromide unaffected by the light and therefore not reduced to metallic silver. The gradation of the yellow-gray to yellow-black is the silver bromide reduced proportionally to metallic silver according to the intensity of the effect of the light. The film, therefore, contains a mixture of silver bromide and metallic silver. Inasmuch as we wish to retain the metallic image, and inasmuch as light will further affect the film unless the unaffected silver bromide is removed, we must necessarily take such precautions as will prevent this from occurring. That is, we wish to fix the image, and this is done by the next step in the developing process. The fixing solution is an acidulated solution of hyposulphite of soda, popularly known as hypo, and has the power of fixing the metallic image and at the same time changing the unaffected silver bromide into a soluble compound which is removed by the wash water. The films are left in the fixing solution for at least fifteen minutes, and when upon examination they show the slightest trace of yellow, the fixing process should be continued until every trace of the silver bromide has been removed. As a final treatment, the hypo is removed from the films by continuous washing in ever changing water. At least one half-hour of washing should be allowed for completely removing the hypo from the films. When this has been accomplished, the films are dried.

Care as to detail is as important in drying as in developing, for films dried too rapidly curl tight and become difficult to handle. Films that are dried in an excessively warm room with no circulation of air are apt to blister. Films that are dried by the current of an electric fan are apt to leave water marks which later may be a cause for error in diagnosis, and are also prone to retain particles of dust that are stirred up by the fan or may be blown from their hangings, to be marred by the fall. Perfect workmanship, like a thing of beauty, is a joy forever, and depends absolutely and unmitigatedly on the attention to details and much attention to the care of the solutions and the manipulating of the films while developing them.

The chemicals should be thoroughly dissolved, best done in tepid water which is also filtered, because in the first instance, if not thoroughly dissolved, the solution has strata of varying strengths, and in the second instance particles of foreign matter cling to the film and are the causes for specks, spots and blemishes, which indicate indifference. Not only that, but the solutions, when not in use, should be covered, the reasons being obvious. The films themselves should be cautiously

handled. It is unwise to grasp them other than by the edges, with thumb and index finger, lest fingerprints appear on them, especially if the hands are ever so slightly moist or have been contaminated by the handling of drugs and chemicals of the routine work of a busy office. Extreme caution in the placing of the films in the solution will be repaid with excellent radiographs. Films in the process of development become somewhat softened, so that the emulsion is very easily scratched by a neighboring film if hung carelessly in the solution. Nine times out of ten these bruises will show up on the film just where they are least wanted, interfering decidedly with diagnosis and provoking the patience of those concerned. It is by far wiser to treat the entire course of developing, fixing, drying, etc., with due respect.

A word or two here regarding dark room equipment would not be amiss. It is essential that the dark room be literally a dark room, utterly and unequivocably free from the seeping in of any light whatsoever. This can be readily obtained by closing one's self in a dark room for not less than ten minutes, by which time the pupils of the eyes will be so dilated that any chinks permitting light to filter in will be easily discerned. These places may be plugged tight with red crêpe paper or many layers of black passe partout may be placed over the opening. Another method is to expose half of a film in the dark room for five minnutes, and then expose the entire film for another five minutes. If, upon developing, the first portion appears darker than the rest, it stands to reason that light has seeped in, and the remedy is obvious.

The whole of the dark room should receive at least two coats of black paint, dull finish. Developing should be done under a ruby light, which may be bought, or made, to suit one's purpose. It stands to reason that the dark room should have a sink with running water, hot and cold, and shelves for the storing of supplies. The workbench should be made to suit the personal convenience of the individual, taking into account his own height. Whatever methods or arrangements are best suited to the individual should under no circumstances be altered; that is, if the developing solution is to the right, let it always remain to the right, the operator then getting the habit of moving from right to left. As a suggestion, let there always be some distinctive characteristic for the developer container so that the solution can be verified in the dark room by feel. The writer, now that the horse has been stolen, locks the barn door; that is, he invariably locks himself in his dark room, once having had a disastrous experience when inadvertently his assistant, forgetting herself, swung open the door and thereby ruined a number of hangers of exposed films.

As accessories to the dark room one should have stirring rod, thermometer, scales, graduate, funnel, and filter paper. These accessories often come in as a great aid to perfect workmanship. The reader must

realize that photography, radiography included, is an exact science within certain limits, depending upon the immutable laws of physics, chemistry and mathematics. These laws will not be infringed upon, being rigidly insistent upon due respect, invariably, or the punishment that will follow lies in the poor radiographic results, of little value for diagnostic purposes, which in turn react as a discouragement and a deterrent to all concerned. Therefore, it is all important that each detail, which in itself might seem unimportant, should be like every rivet and bolt on our stupendous bridges, in that it has its minute effect for good or bad, according to the operator's appreciation of attention to detail.

In the taking of extra-oral films, it is best to make use of an intensifying screen held in a cassette. An intensifying screen is a sheet of heavy celluloid covered over with the crystals of barium tungstate, which has the ability of absorbing an unusual amount of x-rays and then reflecting them back to the film. Hence a film placed between two such screens will more readily take lateral radiographs. These are developed in the usual way, with the additional caution of extreme watchfulness, as the effect of the screens will have left a deeper impression and the developing will therefore go more quickly.

It must be realized that these films are negatives of the object, that is, what in the object was lighter is of a darker tone in the film. If for one reason or another a positive effect of the object is desired, this can very easily be accomplished by the process of printing. The method is quite simple. The emulsion side of the film is placed against the emulsion side of the print paper and clamped together in a printing frame, and exposed to the light for a fixed period of time. The light, passing through the film, leaves its effect on the paper, the intensities being dependent on the intensities of the gray tones in the film. The image is brought out by developing, fixing and washing in accordance with the directions given by the manufacturer. It is wiser in general to adhere to the rules as laid down by the manufacturers of the various items that go into the ensemble. Until the novice has passed the stage of the beginner and is really experienced, it is better to purchase the prepared chemicals all ready for solution, but when he becomes proficient, he may vary his methods and permit himself the making up of solutions of formulae which he may have gathered here and there.

In no time films will gather for recording. The simplest way to keep them on file and for ready access is to place the first films taken of a patient into what is known as a coin envelope, named, dated and addressed. Subsequent films of the same patient may be placed in a smaller envelope, named and dated, and placed in the first envelope which may be filed away in a card index case to be found whenever wanted.

The writer refrains from giving any formulae for developing and fixing as he realizes that in the modern scheme of things the manufacturer sees to it that the proper preparations are available, and that few, unless they are unusually interested and with an experimental turn of mind, will go to the trouble of purchasing the individual chemicals, insisting on their purity, carefully weighing them out per formula, and making up solutions.

Films that have been overdeveloped and turn out too dark are of very little value for diagnostic purposes and should really be discarded. Should it be desired to reduce the intensity, this can be done with reducing agents, but the results are not very favorable. The same may be said of underdeveloped films, which by chemical treatment may be more intensified.

16 Court Street.

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## What the Days Bring to Us As We Advance In Dental Practice

By Frank W. Sage, D.D.S., Cincinnati, Ohio

*(Continued from January)*

Many successful dentists whose names are on the tongues of scores and hundreds of grateful patients have limitations of which even they themselves have no suspicion. Dentists are often like husbands—splendid in most respects, nothing to boast of in others, actually lacking in some. To be sure, they find themselves out—or their patients, quite as likely, find out for them.

This dentist is a fine operator. Such matchless gold inlays as he makes! Nor has he many equals in the line of prosthodontia. Master of all the various appliances for determining movements of the jaws and occlusion of dentures, quick to grasp each and every new mechanical idea as it applies to dentistry, unfailing in results aimed at. In the dental college he was always leaning over a dental chair, learning the very latest as to various restorative operations or busying himself in the laboratory that nothing escape his keen attention and observation. And yet—well, what seems wrong?

It transpires after a while that he wobbles slightly when it comes to pulp treatment. Examines with his magnifying glass the ulcerated surface of an exposed pulp in a molar. Dead pulp, he decides, and rams a barbed broach into it, eliciting a scream from the lady patient. Dead pulp surface; inflamed, highly sensitive major portion of pulp

underneath. Mystery! Never knew a dead pulp to misbehave so. Uncertain what to do about it. Too proud to ask a rival dentist.

This goes on for years, nobody being asked, so he never learns to scrape or drill the dentine somewhat away from inflamed pulp and apply arsenic above the portion of pulp where stasis has occurred. This is today history of a dead past, extraction being the rule for such cases. But for years this dentist has stumbled on in the dark, wondering why it is that he can thrust a broach into the palatine root of an upper molar, causing thereby no pain, while both buccal root canals shriek, metaphorically speaking, when he attempts entrance to them.

From his fingertips to his toes, all mechanic is this young man. Histology and pathology are to him dimly recalled names only. How much time, how much useless treatment of abscessed teeth he might have saved his patients and himself, had he early recognized the fact that a single-rooted tooth containing a dead pulp and showing no improvement after one or two treatments is past all surgery. Upon him the fatal significance of a much darkened crown is lost. Fit only for the forceps—such teeth!

Yet it must be admitted that the dentist who is all mechanic, and in part only or not at all pathologist, is better equipped for the ordinary demands of his patients upon him as a dentist than the other dentist who spends more time over his sealed bottles and his microscope than he does over his dental chair or in his laboratory. If puzzled over pathological conditions he may at all events confer with a physician who is supposed to know—although frequently he does not. I have had more than one family doctor who has called upon me to relieve a bedridden patient of toothache ask, ". . . But why does the tooth ache, if the nerve is dead?"

Talk about the need of a medical course for dentists! No end of physicians ought to be required to take at least a two hours' toothache course at a dental college. The great majority of physicians even at this late date regard a tooth as merely a something you fit a forcep to and twist, in case it aches.

One of the real dangers attending gold inlays, if large, lies in the extensive cutting away of enamel and dentine for insuring a proper withdrawing of the impression wax or compound. Many years ago Dr. Black the elder, of Chicago, declared it only a question of time as to healthy pulps dying by reason of much cutting and removing of hard structure, even though no near approach to the pulp be made. No doubt it is recognition of the truth of his saying that has brought about the new system in many dental offices of summoning patients periodically for examination of their teeth. The system ought to work in small communities as well as in cities, for it gives reasonable promise of painless operations, decay being early detected, of saving of time and

expense for the patient, of permanency of operations. It would stimulate invention of separators far superior to any in use, would save back- and eye-strain for the dentist, would restore courage and confidence in patients demoralized by long, exhausting operations. Thinking over the past, does it not seem a something remarkable that this new method in practice was not long ago adopted? We dentists have entrusted to parents the care of their children's teeth as regards frequent cleansing, dismissing all thought of responsibility, in case of our admonitions in part being disregarded or wholly neglected. The society woman, the club woman, is too preoccupied with matters more important to be twirling a toothbrush in infantile mouths thrice daily.

A once-in-two-months' visit to the dentist should be insisted on or—no further service from you! The dentist needs to impress upon paterfamilias that it is cheaper to pay something for these visits, even though no service be required, than to lie awake some night a year later, disturbed by Bobby or Susie lamenting over an aching tooth.

Meanwhile, install the new method. Have it understood that you will call up once in so often. All days of grace abolished, as in modern banking. Many city dentists are using the phoning method successfully.

How times have changed! What has become of the ten- or twelve-year-old office boy of the '70's?

The young lady of presumed judgment as to handling patients has superseded. No longer does the book agent suddenly appear like an apparition beside your chair as you are operating, thrusting a book between your eyes and your swinging tray. Dentists have as yet no such defensive lines of sub-officials fending off all comers, as have the higher officials of banks and insurance companies. However, a hint at least that the dentist must not be too presumptuously disturbed at his work has gone far abroad.

Better days await the dentist who succeeds in persuading patients to agree to the new system of coming often and staying a shorter time. The effect is sure to be a dying out of the terror attaching for many to the very mention of the dentist. More patients will seek his services. Dentists will be spared the trial of long hours over nervous, captious patients incapable of self control. The real alleviator, not only of pain but of dread, is yet to be discovered. It will surely come.

Recently an article appeared in a newspaper relating numerous removals of great business concerns from large cities to small towns and villages. This article indicated in the near future a general movement of the sort, a repopulating of smaller towns by reason of the demand for living space for employees. This, it said, meant not merely factory hands but the thousands of clerks and higher officials who must give up their city residences and follow the beckoning of the business concern.

If, indeed, this comes about, how may it not affect the town or village dentist? It is likely to make of him a city dentist without the many disadvantages besetting that functionary. It foreshadows for him a class of patients less enervated, presumably, by city dissipations of various kinds—the middle class, not yet enthralled by the artificial burdens and responsibilities of society. A Cincinnati dentist was heard to declare that he wanted no wealthy patients but preferred the middle class. Night after night of feasting, dancing—what a preparation for a sitting with the poor dentist!

Sixty years or more ago, big manufacturing concerns moved from crowded quarters in cities to small towns having facilities for shipping their wares. But they took with them for the most part only a class of craftsmen. Today large insurance companies, printing and publishing houses are removing from congested cities to even rural neighborhoods, carrying with them small armies of clerks of both sexes. This must mean further enlargement, the employment of children and youth, not to omit their elders, of the local community, the bringing to the dentist's door of new patrons, enabling others, perhaps pinched to the limit as to resources, to earn means for paying dental bills.

The city coming to the dentist! Who could have believed it! Newcomers, familiar with the advantages of dental services, inspiring the home residents, shaming them to care for the appearance of their mouths, rousing them from indifference as to the criticism of others. Money circulating as never before, the dentist getting his share!

Dentistry is one of the most attractive callings that could be named for any young man looking for an employment in which he may work as little as he pleases, loaf all he pleases. It is all right for the fellow whose idea of life is to work some and play a good deal. It usually disappoints such as expect patients to make due allowance for the dentist who has a manifest affection for a gun or fishing tackle, overbalancing regard for his patients' urgent necessities. The mixed work-and-play expectation "plays" out, prematurely. At sixty the dentist who persists in reasoning along such lines may sometimes be found driving a dirt cart on a country road.

Seriously, money may be made in practicing dentistry. Of course, if anyone wants to become a sort of missionary without attaining the usual honors and respect attaching to self-sacrificing service in a spiritual way, he may easily accomplish it. Struggle to gain a reputation for satisfactory service; spare no pains, dodge no obstacles, have the courage to admit you have been on the wrong track even after hours of labor, if it comes to that. Begin all over, no matter if the patient shows resentment. He will speak well of you afterward.

Remember the advice given by one of Shakespeare's fathers to a relative, a youth about venturing into the unknown world:

"Give every man thine ear, but few thy voice."

"Take each man's censure (advice), but reserve thy judgment."  
(*Hamlet.*)

If all dentists were as to character, disposition, discernment, what many dentists naturally are, such articles, such advice as all the foregoing might be left unwritten. The president of Columbia University, New York, years ago declared that the student's education must in time come to include correction as to the three above-named personal qualities and a few others to be studied out by the professors. But the difficulty would be to find professors who could or would do that. They might fear uncovering some of their own defects. Same as dental college professors!

Let us live in hope as to the coming generations of dentists.

No. 22 The Parkside.

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## Going Up!

For just a little while we *play* in meadows starred with flowers,  
And then begin to climb the hill which far above us towers—  
Towers so high, we cannot scan conditions on its crest,  
Or tell if places there may be where we can stop and rest.

Mists veil the peak, but, here and there, the sunlight pierces thro',  
And straight the path leads up the side, towards the *Ever New*.  
Boldly we scale the lower heights and urge on those below—  
"There is a long, long climb ahead—you must not be so slow."

The road grows rougher; shadows fall, fierce storms break overhead,  
The tender feet, which danced at first, are bruised and torn and red.  
Early some fall, too frail to stem the torrent, rocks and shoal;  
Others press on and gain the peak they deemed the final goal.

Arrived, they find the trail leads *down*, slowly at first, then sheer:  
Not distant now can be the end—a day, a month, a year?  
And then at last, the journey o'er, pray that it please the Powers  
To grant again that all may *rest* in meadows starred with flowers.

—G. H. C. in *Clinical Medicine*.

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## A Simple and Practical Unit for Use In Impression-Taking\*

By Alfred Walker, D.D.S., New York, N. Y.

This is a new use for an old friend. The cellarette has been converted into a unit containing everything that may be required for use in taking impressions. It is mounted on ball-bearing casters, is rolled up to the chair easily and silently and is then at your service.



THE CELLARETTE

\* From a clinic given before the First District Dental Society, New York, December, 1925.

## Dr. E. S. Gaylord

A Tribute From  
William Lyon Phelps, New Haven, Conn.

Lampson Professor of English Literature at Yale University

Doctor Gaylord died at the age of eighty-five; he had practiced his profession in New Haven for sixty consecutive years. For well over forty years he had been my family dentist. But he was also my neighbor and intimate friend, so that I knew him both professionally and personally. My respect for him as a practitioner was equalled by my affection for him as a man.

Doctor Gaylord had that prime quality of the first-rate scientist—an open and hospitable mind. He was always abreast of the times. He took in the leading dental publications, periodicals and special articles, and was eager to adopt any new method as soon as it appeared to him to be an improvement. This alertness of mind never deserted him; it was just as characteristic of him after he was eighty as it was in the earlier years. Thus he never grew old.

When I was a little boy in Hartford, my dentist was the late Doctor Parmelee. He often spoke of Dr. Gaylord, sent special patients to him and had him in consultation, so that Dr. Gaylord's name was familiar to me long before our family moved to New Haven.

In the year 1908 I had an emergency case while traveling along the Pacific Coast. I consulted Doctor Shaw, of Seattle; he asked at once who my home dentist was, and when I gave the name, he said, "Oh, I know Dr. Gaylord very well. All American dentists look up to him as their chief."

On two occasions, a number of years apart, I had the pleasure of speaking at banquets given in honor of Dr. Gaylord by a large number of his colleagues in the Eastern States. It was highly gratifying to see how our home-town expert was regarded by his peers—by those who were best qualified to judge of his scholarship and skill.

I remember when Dr. Gaylord built his house, what pride he took in building the operating and consulting room and laboratory. He had a magnificent north light, and every kind of modern implement with which to work.

One reason for his success was that his whole heart and mind were in dentistry. It was both his work and his recreation. After his day's work at the chair was over, he invariably sat up till midnight, either working in his laboratory or reading some recent article on his specialty. To him his profession was all-absorbing; he did not look upon it as a mechanical means of livelihood and seek his enjoyment in vacations

and hours of freedom. His chief joy was in the work itself. This helps to explain his great success, and also his eternal youth; for a man who is deeply and constantly interested in his work is never wholly unhappy nor can he really grow old.

Yet the Doctor was a man as well as a dentist. In his brief summer vacations he went into the woods; and when he could get a fortnight of leisure in the autumn, he went shooting with boon companions. He loved sport, he loved men, and he loved dogs. Indeed, I think his absorption in his profession combined with his love of congenial company in primitive camp life was unusual, for he was always a good fellow.

Time never counted with him. He never hurried through one appointment to reach the next. If you were his patient and he was operating, you knew that he would not let you go until he had finished the work to his own complete satisfaction. He was deliberate, because he was careful; but he never wasted his time or yours.

I think I ought to add that he was always and everywhere a gentleman. I never heard him use a coarse or profane expression, and I never saw him peevish or petulant. He was always calm and self-controlled, like a master who knew he was equal to any undertaking.

He had a rare sense of humor and loved a good story. No one could ask for a better dinner-companion.

We shall all miss him, and we shall never forget him.

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**A Tribute From  
Dr. James Leon Williams, New York, N. Y.**

It is a very great thing to have lived a long life in such a way that prompts those who came into the most intimate contact with that life to say, "Here was one of God's true noblemen."

It was my privilege and great pleasure to live for nearly two years in intimate professional association with Dr. Edward S. Gaylord. I have known many eminent men in our profession, in America and in Europe, but no one whom I would place above him in perfect consistency of unimpeachable character and purity of high professional ideals. In all of our many consultations over cases the question for discussion was always the same: "What is the best possible thing to be done for this patient?" I do not believe that he ever allowed weariness or pressure upon his time, or any other consideration, to influence him to swerve an iota from that attitude of mind.

Dr. Gaylord was not what would be called a "brilliant" man. He reached the very high position which he held in the universal esteem, admiration and love of his confrères by sheer force of a noble character built upon the foundation of sterling integrity and transparent honesty. He attained a high degree of skill in his profession not so much because of any marked natural aptitude for his work but as the result of an inflexible, persistent determination to let nothing leave his hands that did not represent the best he was capable of doing. It was these qualities which inspired all young men who came in contact with him.

The fine dignity and poise of the man, which were often remarked, were the natural result of a self-respect born of a consciousness that harbored no mean or petty aims in life. He was, withal, a modest man and disposed to distrust his abilities in any field outside his professional work.

In this connection I recall the events preceding his election as President of the National Dental Association. A friend came to my hotel room at the Denver meeting and said: "We want Dr. Gaylord for the next President of the Association, but he positively refuses to permit his name to be presented for nomination. He says he can never be elected. We believe you can influence him to change his mind. Will you see him immediately, as there is not a moment to be lost?"

I went at once to his room, and he repeated the opinion that his election was impossible. I said: "I will not discuss that point, but will you accept the nomination if it is tendered you?" After a few moments' silence, he said: "I suppose it will be my duty to accept the nomination if the profession calls for me, but I think it will be a mistake."

Of course, he was nominated and overwhelmingly elected, and he made one of our best presidents.

I am sure that a long, formal, laudatory obituary notice would be as displeasing to Dr. Gaylord as to me, and I will add only this to what I have written—I, who knew him well, say that he was a fine Christian gentleman.

160 Riverside Drive.



## One Cancer Patient Improving

By George Wood Clapp, D.D.S., New York, N. Y.

The August, 1925, issue of this magazine carried an article on the treatment of cancer by a method which has satisfied certain investigators that it has great merit, but which has not yet received official medical approval and which, in fact, has been visited by something like official condemnation. The note which was placed at the beginning of the article briefly stated these facts, but because of my confidence in the author of the article, based on long acquaintance, and because of the very serious threat to individuals and the community from the prevalence of cancer, the article was published for what the readers might consider it to be worth.

Up to the 8th of December, 1925, when this is written, there have been received from this article thirty-six letters of inquiry, three office calls for treatment and one order for treatment by cablegram from Africa. Practically all of these resulted from the fact that dentists had a vision bigger than mere dental work, and presented the subject to someone in their clientele or among their friends to whom it was important. No one can read the letters which have been received without being tremendously impressed with the conviction that if Dr. Koch has found a treatment which results in something like a clinical cure for inoperable cancer cases, even if the cure is not such as might technically satisfy a diagnostician, he is in position to benefit humanity greatly. If people who are looking out upon a future that contains only a prospect of early death by a painful disease can be sent back to work in at least reasonable comfort and there can be lifted from their minds the terrible and never-quitting fear, it is worth the while of this magazine or any other to bring the possibilities to their attention, even if the record of success is not so long and convincing as we wish that it might be. These people have everything to gain and nothing to lose, and Dr. Koch and Dr. Hoyt are convinced that great benefits are possible, at least in certain cases.

Because this magazine is occasionally criticized for publishing material which is not strictly dental, it will be interesting to reproduce here either summaries or extracts of a few of the letters so altered as to escape detection of the source while preserving the sense, merely to refresh our minds as to the overwhelming importance of the subject to those who are afflicted or who have afflicted loved ones.

One of the first inquiries was from a young wife:

"Please write me how to get in touch with Dr. Koch. . . . My husband was operated on a month ago and a tumor was found in

the upper bowel and the case is inoperable. He is only 26 years of age. I should like to get there as soon as possible.

Pennsylvania."

In reply to this inquiry, Dr. Hoyt advised her to take her husband to see Dr. Koch at Detroit, Michigan.

On November 25th the lady wrote me as follows:

"In reply to your letter of November 11th, I doubt if my husband would be here today if it were not for the article published in *The Dental Digest*.

"He was operated on in July. The doctors at home pronounced him incurable and told me he could live only a very short time. The 29th of July I took him to Rochester, Minn. He was given a thorough clinical examination there and was examined by Dr. Will H. Mayo himself and pronounced incurable.

"We were just home from Minnesota for one week when I happened to find Dr. Koch's cure in your 'Dental Digest,' and I asked the dentist for the book. I wrote to Dr. Hoyt and he advised me to bring my husband here at once, and I did.

"He is recovering just splendidly. The treatment has surely done wonders for him already. The tumor mass in the colon is going fast and the rest is all gone except a small implantation on the rectal shelf. As I understand it, it will be the last to leave.

"He has a very good appetite now and is a great deal stronger. When I brought him here, he was so weak that he almost staggered when he walked. Now he goes down town alone.

"If there is anything else you wish to know, just write and ask me and I'll be just too glad to answer. I know if it hadn't been for the article in your magazine, we should never have heard of this wonderful cure, for none of the doctors in our town knew anything about it.

Yours truly,

Mrs. H. R." (Name and address on request.)

It should be remembered that I do not know Dr. Koch, or this lady or her husband, and have never seen any of them. Information about this case reaches me from another source than this letter and confirms what is written. Because of its great importance the information is given without endorsement or prejudice.



## Togo's "Discussions"

*Mr. Editor of Magazine seeking to make Dentistry Digestible if Possible.*

*Hon. Sir:—*

Letters of Japanese aroma appearing recently with unscrupulous regularity have caused noticeable relief of brain pressures heretofore present, therefore subjects of vociferous interest to all Dental Practitioners & some men will be considered & disposed of as rapidly as possible.

Times are changing with exotic rapidity in land of Hon. Uncle Sam, Henry Ford & Mr. Volstead. Low-brow Saloon controlled by cigar eating politicians has given way to hip pockets which nobody can control. Bob sled & hay rack parties enjoyed by former generations of healthy youngsters in groups of safe size have now been replaced by excursions consisting of two as maximum number conducted with assistance of any gasoline gurgler available & in approximate running order.

Names of Dickens, Thackeray, & Scott, because not erupting as part of winning college football team are unknown to rising generation of students which is possibly doing so with more suddenness than soundness in many cases.

Many more shortcomings could be decapitated in effort to draw picture showing distressing fact that "Times are out of joint" (as Hon. Shakespeare once observed while entertaining severe headache). But are they? Only partially so Mr Editor & then chiefly on exposed surfaces.

All liberties recently removed from high powered individuals are deeply resented—at first. Later comes blessed forgetfulness & indifference to fact that such liberties were ever really enjoyed or highly prized by sane persons of former generation.

Age old program of personal revenge for personal wrongs took generations to disappear but has finally been covered with slowly rising tide of public disapproval with only ugly fragments occasionally coming to the surface in mountain regions of decidedly certain States & slums of great cities.

Changes of equal disturbing magnitude Mr Editor are occurring in profession of Dentistry which is now being practiced on more extensive scale in U.S.A. than ever before in history of entire World.

Owing to peculiar fact that adult teeth have in most cases refused to stay on Hon. Job to date of old age, public consciousness has been slow in placing sufficient value on great use & beauty of said organs. "Bound to be lost sometime! Why not now?" were delightful & economical thought occurring in brains of 45 years & upwards.

Mental attitude of Hon. Public had large influence in causing Dental Profession to be satisfied with results of very ordinary or mine run variety which gave fragmentary satisfaction for perhaps short time only.

However, methods of last twenty-five years have shown ambidextrous improvements in tooth salvation & Hon. Public of age 45 & upwards is now rising up and stating in voice denoting great interest—"Youth of twenty half baked summers can fluently enjoy beef steak, nuts & salads Why can't I" & then proceeds to place problem before Experienced Dentist in order to obtain answer consisting of delightful words "You can" in exchange for Cash Payment of considerable proportions.

Result of this awakened attitude of Public Mind Mr Editor is astounding fact that only occasional dentist can be found who is really delivering services which are now being sought by buying public which usually has enough money to do so.

Hon. Doc. Oldtimer is still pasting in flat amalgam pancakes completely equipped with odorous germ retainer at gingival border; such cadaverous dental work develops full efficiency in halitosis department only. On other hand is monumental fact of splendid services being rendered to delighted patients by gold inlays in all approximal surfaces of molar & bicuspid teeth, at cost prices within the reach of all persons able to wear silk sox & happy smile—meaning practically entire population in case of U.S.A. citizenship.

Really high class Dentistry Mr. Editor is easiest commodity now on market to sell to all adults of white or near white race; most of them need it & all are capable of using it with complete satisfaction once it has been properly built & installed which is statement which cannot be truthfully made of Radios, oil burners, wooden legs, toupees & other household ornaments.

Why then are wholly indifferent amalgam fillings, gold crowns, partial plates & other deleterious substances being turned out in such large quantities by dental profession? Answer, Chiefly because Hon. D.D.S. does not take sufficient trouble to first completely convince himself of greater benefits to patient resulting from higher grade of tooth service & then pass on glad tidings to shrinking patient occupying chair for first visit while listening to cheerful tales of what is going to happen & how much.

Greatest thanks should be given to host of inventors, investigators & manufacturers who during recently elapsed twenty-five years have made such strides in methods, tools, technic & workmanship that it is now entirely possible for intelligent & conscientious dental practitioner of only usual abilities to produce really high grade services for practically all classes of people at cost prices which can be paid without necessity of selling family car & which will create yearly income of

sufficient size to enable education of family & production of nest egg during ordinary lifetime or possibly a few days sooner.

Hoping you are the same

Togo.

## Dental Society of the State of New York

The fifty-eighth annual meeting of the Dental Society of the State of New York will be held at the Hotel Astor, New York City, May 19, 20, 21, 22, 1926. An exceedingly important and interesting program will be presented, the essayists and clinicians being men of national reputation.

The Society extends a cordial welcome to all members of the American Dental Association.

### EDUCATIONAL COURSES

Prior to the regular meeting of the Society, three days will be devoted to a series of Educational Courses on Monday, Tuesday and Wednesday, May 17, 18 and 19, 1926.

Through the courtesy of Columbia University and New York University, all the courses will be conducted in the college buildings of their Dental Schools, thus affording exceptional opportunity for effective teaching. The following courses and teachers have been finally selected:

*Partial Denture Construction.* Teachers: Henry W. Gillett, New York, *Wire Clasps*; George P. Phillips, Boston, *Nesbett Technique*; J. Galvin Woodworth, Chicago, *Continuous Clasps and Cast Clasps*.

*Full Denture Construction.* Teachers: F. M. Hight, Houston, Texas, *Articulation*; James P. Ruyl, New York, *Esthetics*; Russell W. Tench, New York, *Impressions*.

*Fixed Bridgework.* Teachers: James Kendall Burgess, New York, *Pinledge Attachments*; M. Diamond, New York, *Carving Teeth*; T. W. Maves, Cleveland, *Carly Preparation and Inlay Abutments*.

*Removable Bridgework.* Teachers: Charles F. Ash, New York, *Split Bar Attachments*; L. W. Doxtater, New York, *Peso and Other Attachments*; Samuel Millard, New York, *Chayes Attachments*.

*Porcelain Work.* Teachers: Milton Cohen, New York, *Carving and Staining*; William A. Squires, New York, *Shoulder Jacket Crowns*; George A. Thompson, Chicago, *Shoulderless Jacket Crowns*.

*Root Canal Therapy.* Teachers: Harry B. Johnston, Atlanta, Ga., *Johnston Improved Callahan Technique*; M. L. Rhein, New York, *Rhein Technique*; R. Ottolengui, New York, *Radiography*.

*Periodontia.* Teachers: John Oppie McCall, Arthur Merritt and Paul Stillman, all of New York, *Periodontic Methods for the General Practitioner.*

*Orthodontia.* Teachers: Herbert Pullen, Buffalo, and J. Lowe Young, New York, *Theories and Practical Work Within the Realm of the General Practitioner.*

*Scientific Removal of Teeth.* Teachers (all from New York): M. I. Shamberg, *Impactions*; Douglas B. Parker, *Elevator Technique*; Francis McCaffrey, *Forceps Technique*; Theodor Blum, *Removal of Infected Teeth and Eradication of Foci of Infection*; Charles Vetter, *Nitrous Oxide and Oxygen*; Joseph Schroff, *Pathological Lesions of Interest to Those Who Remove Teeth*; Henry Sage Dunning, *Accidents and Complications in the Removal of Teeth.*

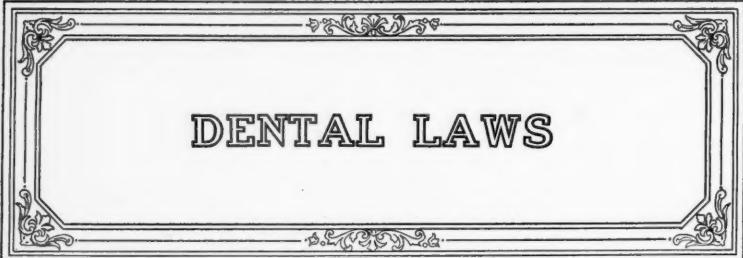
*Local Anesthesia.* Teachers: Leo Stern and Joseph Joffer, New York. Other teachers will be added if the classes are so large as to require it. The evening sessions will be open to all registered in the Exodontia and Anesthesia Courses.

The courses are not restricted to New York State members.

A pamphlet giving details of all the courses and terms will be ready for mailing about February 15, 1926. For a copy of this pamphlet address Edward Kennedy, Chairman Committee on Educational Courses, 347 Fifth Avenue, New York City.

A. P. BURKHART, *Secretary*,  
57 East Genesee Street, Auburn, N. Y.





## DENTAL LAWS

### Summary of Dental License Requirements Throughout the World

By Alphonso Irwin, D.D.S., Camden, N. J.

#### PORUGAL

##### DENTAL LICENSE REQUIREMENTS AND REGISTRATION IN PORTUGAL

In order to practise dentistry in Portugal, a medical degree must be secured, as dental surgery is considered a specialty similar to other branches of medicine. Address the Faculdade de Medicina da Universidade de Lisboa, Campo dos Martyres da Patria, Lisbon, for complete details in this connection.

Official advices from Lisbon, Portugal, verified June 27, 1923.

##### MEDICAL REQUIREMENTS FOR A LICENSE

Elementary education extends between the ages of 6 and 12 years, thus overlapping the work of the lyceum, which extends between the ages of 9 and 16. This is followed by a course of one or two years in a faculty of philosophy (Coimbra) or in the polytechnic schools (Lisbon and Oporto) and then five years in medicine for the degree of licentiate in medicine and a sixth year for the degree of doctor. The time for the entire course is at least eighteen years and minimum age at completion 24. For Board of Health service a special course in sanitary medicine is required; for Army and Navy service, a further course is required in bacteriology, parasitology, hygiene, climatology and tropical diseases.

The medical course covers a period of five years, extending each year from October to July. Matriculates must have had seven years of preliminary education, including Latin, French, and German, and in addition must have studied physics, chemistry (inorganic, organic and chemical analysis), zoology, and botany, and in one of the three medical schools, mathematics. Foreign applicants may be admitted for the examination if they submit satisfactory evidence that they have taken a complete course in medicine in some school of high scientific

reputation. After completing the state examination the applicant may get a degree of Doctor in Medicine and Surgery by submitting a thesis prepared especially for this purpose and approved by the faculty. The fees aggregate about \$300. (Revised November, 1919.)

Portuguese Colonial Possessions include Angola or Portuguese West Africa, Cape Verde Islands, Portuguese Guinea on the Coast of Sene-gambia, Mozambique, Portuguese Inda, Micao, China, an island, and Portuguese Timor. Where dental laws are enforced in her colonies they are the same as the dental license requirements and registration in Portugal.

In order to practise dentistry legally in Portugal, and its possessions, a medical degree must be secured, as dental surgery is considered a specialty similar to other branches of medicine. Address the Faculdade de Medicina da Universidade de Lisboa, Campo dos Martyres da Patria, Lisbon, for complete details in this connection.

Official advices from Lisbon, Portugal, verified June 27, 1923.

#### PRINCE EDWARD ISLAND

LAW AMENDED MAY 15, 1919

Board of Dental Examiners: President, F. E. Smallwood, Charlottetown, P. E. I.; Reg. Secretary, J. S. Bagnall, Charlottetown, P. E. I.; Thomas Robinson, Charlottetown, P. E. I.

The dental laws are dated 1891, 1900, 1904, 1906, 1919. Amended 1924. Examinations are held at the time announced by the Board at Charlottetown, P. E. I. Fee \$15.00.

Requirements: Preliminary education. Matriculation into an Arts Department of a Canadian University. Professional graduation from a dental school recognized in Canada or the United States of America. Theoretical examinations upon the subjects usually taught in a standard dental college, and practical tests are announced.

The Certificate of Qualification by the Dominion Dental Council and dental diplomas from recognized dental colleges are registered. Registration fee \$15.00. Annual registration fee \$1.00.

The Prince Edward Island Dental Act of 1902, incorporates the Dental Society of Prince Edward Island, which controls under the law the practice of dentistry in this Province:

A register of legal practitioners must be kept, and no name can be recorded therein without a duly issued certificate, issued by the Provincial Secretary; I quote from Section 9 of the Act: "That such certificate shall be issued by the Provincial Secretary upon production to him of diploma of graduation in dental surgery from the Faculty of

a Canadian university, having a special dental department, or from any such institution duly authorized by the laws of Great Britain or any of her dependencies, or from any dental college in the United States of America, recognized by the National Board of Dental Examiners of the said United States of America." The fee for this certificate is \$5—and the council, consisting of five members of the society annually elected, can establish an annual fee; quite a severe penalty can be meted out to one practising without obtaining this certificate of registration.

No person can practise dentistry for fee or otherwise in any public street or common or in any park square or in any other public place, without liability to prosecution and penalty. "Any person holding the degree of B.A. from any University recognized by the By-Laws of the society, or anyone holding a second year certificate from the Prince of Wales College, shall not be required to pass the matriculation examination. Any person in possession of a diploma from a college of dentistry, recognized by the council may be registered by the registrar without examination, provided that he possesses the scholastic qualifications required by the By-Laws of the society, otherwise the applicant must pass the matriculation examination, hereinbefore mentioned. This requisite is practically such qualification as would enable one to matriculate at any first-class college. A candidate for a license to practise dentistry must qualify as follows: He must be of the full age of 21 years; he must forward to the secretary-register-treasurer 14 days before examination, a written application accompanied by a satisfactory certificate of character; the license fee of \$15 must be paid before the examination takes place; the matriculation certificate must also be produced or satisfactory evidence given of its having been granted; he must pass an examination before the Board of Examiners on the subjects usually included in a dental examination, and shall perform operations in the mouth and give practical evidence of skill in prosthetic dentistry.

"The examinations shall be written, oral and clinical and comprise the following subjects: General and practical anatomy, physiology, chemistry, operative dentistry, dental therapeutics and other branches, usually required for a dental education. A candidate is required to make 65 per cent in all papers to pass the matriculation examination. 60 per cent passes in the case of a candidate for license to practise dentistry. Again I quote: "Any person holding a certificate of qualification from the Dominion Dental Council, recently organized, shall be entitled to be registered and have his name entered in the 'Prince Edward Island Dental Register' as a qualified practitioner."

J. S. Bagnall, Registrar, Charlottetown, Prince Edward Island.

## CHAPTER 24

## AN ACT TO FURTHER AMEND THE PRINCE EDWARD ISLAND DENTAL ACT. ASSENTED TO MAY 15TH, 1919

Be it enacted by the Lieutenant Governor and Legislative Assembly of the Province of Prince Edward Island as follows:

1. Section 2 of 6 Edward VII. Cap. 27 is hereby amended by striking out the words "or second class" in the fifth line thereof and inserting the words "or third year's certificate from St. Dunstan's University" in lieu thereof.
2. That this Act shall not apply to students who may register as students in the Dental Students Register in Prince Edward Island on or before the first day of October, 1919. Nor shall it apply to Prince Edward Island Dental Students now attending and taking a course in any recognized dental college, and all dental students mentioned in this section may register in Prince Edward Island at any time within six months after their graduation.
3. Section 2 of the Act 6 Edward VII. Cap. 27 entitled "An Act to further amend the Prince Edward Island Dental Act" is hereby further amended by striking out the letter (a) in the first line and inserting the letter (c) in lieu thereof.

## PRUSSIA

The practice of dentistry in Prussia is regulated by certain provisions of the Federal Law regarding the examination and licensing of dentists in Germany. These provisions of the law cover the questions involved from a Federal medico-dental standpoint. Many of the German Medical Colleges teach dental courses.

For general information to alien dentists: It is not believed that economic conditions at present are favorable to the establishment of a dental practice in Germany by a foreigner. There is no particular prejudice against foreign dentists as such; in fact, dentists who have received their degrees from recognized American dental colleges are generally considered as superior to others, but it is not believed that anyone opening an office at the present time would be able to build up a satisfactory practice as rapidly as might be considered desirable. This impression is borne out by the fact that a number of American dentists who formerly practised in Germany have closed their offices and returned to the United States or gone elsewhere.

For detailed technical information address the National Dental Association: Reichsverband der Zahnärzte Deutschlands, Bülowstrasse 104, Berlin W 57, Germany.

Verified May 11th, 1925.

## FRANKFORT-ON-MAIN, PRUSSIA

The practice of dentistry is open in Prussia to anyone who pays the required fee, and causes his name to be inscribed in the Gewerbe-Register (Industrial Register).

Formerly, academic titles conferred by foreign institutions of learning were pretty generally recognized, but since 1897 the situation is as follows:

According to a decree of April 7, 1897, foreigners residing in Prussia cannot make use of an academic title conferred by an institution outside of the German Empire, unless special permission has been obtained from the Prussian Ministry for Religious, Educational, and Medical Affairs. This decree did not apply to titles conferred before that date. There are consequently a number of American dentists here, established before 1897, who are allowed to make use of titles conferred on them by American dental schools.

At present, an American dentist can practise here after inscribing his name in the Gewerbe-Register, but he cannot call himself Zahnarzt unless he has obtained permission from the Prussian Ministry in Berlin. In the local directory, dentists who have received their degrees in Germany are classed as Zahnaerzte (dentists), whereas those who have been prepared abroad are called Zahnheilkundige—approbiert im Ausland (Skilled in dentistry—examined abroad).

There are a number of dentists at Frankfort, and it is doubtful if there is much opportunity here for young dentists, unless they should be taken into some well-established office.

## PUEBLA (MEXICO)

Inasmuch as the unsettled condition of affairs in the States of Mexico gave rise to contradictory reports of the business prospects in various sections of that country, we caution dentists to look before they leap. Inspect the conditions! Judge the outlook: visit Mexico. Under the title of Mexico we presented viewpoints from different officials and states in Mexico received during the last few years in regard to dental practice, and the possibilities which may be realized by an alien dentist locating in that land, including the Mexican Federal (1920) Dental Law, which is enforced in the largest cities and the most populous centres in which laws are enforceable. See Mexico for the dental license requirements operative in the State of Puebla.

## PROVINCE OF QUEBEC (CANADA)

Board of Governors of Dental Surgeons is the supreme body in the Province of Quebec, Canada. President, Jos. Nolan; Vice-President, Ernest Charron; Secretary, Denis Forest; Treasurer, Armand Massi-

cotte; Registrar, Theo. Cote; Jack Rubin, C. M. Barr, Alex. Lemieux, V. Olivier, T. Asselin, Governors.

The Board of Dental Examiners includes: President, Ernest Charon; Vice-President, Valimore Olivier; Secretary, Denis Forest; Treasurer, Armand Massicotte; Registrar, Theo. Cote.

The dental laws are dated 1909, and amended as in force March 15, 1924. University supervision, examination, licensure and registration are required. April and October examinations are held, or as announced. License fee \$60.00. Matriculation, examination, license and registration fees totals are charged according to the schedule provided in the by-laws. The English or French language is used in conducting examinations. The dental laws authorize the formation of by-laws governing examinations, the establishment, equipment and conduct of dental colleges, and rules regulating the legitimate practice of dentistry in the Province. This authority is vested in The Corporation of the College of Dental Surgeons of the Province of Quebec.

In the final examination the student must obtain at least 50 per cent in each subject and 60 per cent on the whole. 100 is the maximum; 75 and over is first class; 66 is second class.

Sec. 11. Candidates who fail in any one or more subjects of the primary, will be obliged to pass subsequently upon the subjects in which they have failed and will not be eligible for final until they have passed all the primary. Candidates who fail in any one or more subjects in the final, will be obliged subsequently to pass in all the final subjects in which they were examined.

Sec. 12. Examinations will be held at the regular meeting of the Board in April and supplementary examinations in October of each year in accordance with the act of incorporation. A supplementary examination shall only be held provided that the candidates can provide a sum sufficient to cover the necessary expenses, which sum will be decided by the Board.

Sec. 13. The fee to be paid for the certificate of license shall be \$60, and the candidates who fail to pass the final will be refunded \$30.

Sec. 14. The examinations under Art. 4081, Act of Incorp., will comprise: Prosthetic dentistry in metals, vulcanite, etc., theory and practice (two subjects); dental metallurgy; crown and bridge work, theory and practice (two subjects); dental pathology, therapeutics and *materia medica* (two subjects); operative dentistry, theory and practice (two subjects); irregularities and dental surgery (two subjects).

In the case of applicants for the license who have successfully passed the D.D.S. exams. of the universities, the Board may waive further examination on the recommendation of its assessors.

For further information, apply to the Secretary, Dr. Denis Forest,  
187 De La Roche, Montreal, Canada.

Verified February 25th, 1924.

#### NOTE THE FOLLOWING

*Certificate of Competency:* All holders of the degree of Bachelor of Letters or of Arts or of Science from one of the universities of this Province are eligible for examination in the Province of Quebec, providing the candidate possesses the degree of Doctor of Dental Surgery granted after a four years' dental course by a University in the Province of Quebec. A completed second year Arts course in an approved university of the Province also entitles the dental candidate for examination to a Certificate of Competency, which is a pre-dental requirement from the applicant for a license to practise dentistry in the Province of Quebec, Canada.

There does not appear to be any *specific* provision in the dental law of the Province of Quebec for the examination or licensing of alien dentists, or even British dentists with British credentials outside of the Province of Quebec.

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#### Notice

The Florida Dental Law which became effective January 1, 1926, requires annual registration with the Secretary of the Board of all who hold license in Florida.

R. P. TAYLOR, *Secretary-Treasurer*,  
414 St. James Bldg., Jacksonville, Fla.

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# DENTAL ECONOMICS

## Could He Appeal?

By M. L. Hayward, Hartland, N. B.

The salesman was pushing a new line and had sold the local dentist \$1,000 worth.

"Remember that we take a 3-months' note for the price of this stuff without interest," the salesman pointed out, filled out a note form, and pushed it across the desk.

"What's the meaning of that statement, 'The maker hereby waives any and all rights of appeal in any suit brought on this note, or any renewal or renewals thereof'?" the dentist asked.

"Oh, that's simply printed in all our note forms. It means that if you were a poor customer, which you are not, and refused to pay this note, which you will not, and we sued you and got a judgment in court, you couldn't appeal to a higher court and keep us out of our money indefinitely," was the airy reply.

When the goods arrived, however, the dentist found that they "were not worth lugging home," as the freight agent expressed it. The seller refused to take the goods back, the dentist refused to pay his note, the seller sued and got judgment.

"What's the next step?" the dentist asked.

"The judge who tried your case knows no more law than necessity, and some of his rulings on evidence would make a cowboy justice of the peace laugh," his lawyer assured him. "We'll appeal and win without a struggle."

"What about that clause in the note that I signed, saying that I waived my right of appeal?" the careful dentist queried.

"That's a new point, and we'll have to meet it on appeal," the attorney admitted, "but it's my positive opinion that no court will permit the maker of a note to sign away his legal rights in that way," and the Supreme Court of Idaho, in a case reported in 219 *Pacific Reporter*, 1058, ruled that the attorney was right, and the weight of authority is to the same effect, although some courts have ruled the other way.

"The effect of such a stipulation is to oust the court of their juris-

diction and to restrict the parties from enforcing their rights under the contract by the usual legal proceedings in the ordinary legal tribunals. There is some conflict of authority upon this subject in the reported cases, but we do not think, in view of the foregoing statute, that the question is open to discussion in this State," was the reasoning of the Idaho Courts.

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*In the March issue we shall  
give a Court's decision  
on an unusual  
UP-TO-DATE CHECK*

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## PRACTICAL HINTS

This department is in charge of V. C. Smedley, D.D.S., and George R. Warner, M.D., D.D.S., 610 California Building, Denver, Colorado. To avoid unnecessary delay, Hints, Questions and Answers should be sent direct to them.

NOTE—Mention of proprietary articles by name in the text pages of the DENTAL DIGEST is contrary to the policy of the magazine. Contribution containing names of proprietary articles will be altered in accordance with this rule. This Department is conducted for readers of the DENTAL DIGEST, and the Editor has no time to answer communications "not for publication." Please enclose stamp if you desire a reply by letter.

### *Editor Practical Hints:*

I have a patient, 29 years old, whose right upper cuspid is not fully erupted—the tip barely peeping through the mucous membrane. There is not space to accommodate its eruption. Would the extraction of one of the approximating teeth cause the eruption of this tooth? What would you advise me to do?

L. G. C.

ANSWER.—I do not believe any general practitioner should assume the responsibility or decide to extract one sound tooth to make room for another in a crowded arch, at least, not without first having made and studied complete mouth x-rays of the roots of the teeth in the jaw, and made accurate occluded plaster casts of the complete dentures for study of the mechanics and esthetics involved.

The right thing to do if it is at all feasible is to refer such a patient to an orthodontist or one devoting some special attention to that type of work—V. C. SMEDLEY.

### *Editor Practical Hints:*

I am enclosing x-ray pictures of a case of mine, who is troubled with a swelling the size of an olive immediately under the ramus on his right side. Although this mass is not particularly hard nor painful, it is very annoying to him, especially when he turns his head or lowers it so that it touches his collar.

The patient's physician, not suspecting malignancy, advised him first to have these teeth x-rayed before a definite diagnosis could be given.

Another case that I would like information about is that of a child, eighteen months old, who has an unusual amount of black stain on the

labial surfaces of his upper and lower teeth. The teeth erupted normally, and are in perfect alignment. The child was a breast fed baby, and the usual amount of supplementary feeding of orange and tomato juice was administered. After the teeth erupted, this condition took place.

What in your opinion is the cause of these deposits, and do you think it is safe to brush them off with the usual prophylaxis procedure? The baby is perfectly healthy, and is unusually large for his age. Physical condition of both father and mother is good, with no constitutional symptoms.

Any information you can give me concerning these two cases will be greatly appreciated.

I. A. L.

ANSWER.—In regard to your first case, it would seem to me that the simplest explanation of the swelling is infection from the first molar having burrowed its way down under the soft tissues and opened out at the point of the swelling. The radiogram of the first molar doesn't show enough alveolar structure below the apices of the roots to confirm or disprove the diagnosis offered. I would suggest therefore putting the radiogram at a very low angle to see if a fistulous tract can be shown. But whether a fistulous tract can be shown or not the swelling ought to be opened and if suspicions are aroused as to its being malignant a specimen should be taken and microscopic examination made. The bone in the periapical area of this first molar is not normal and healthy and it wouldn't be amiss to extract this tooth and probably its extraction would clear up the whole difficulty. It would be wise when the tooth is extracted to clean out the old amalgam in the second molar area.

In regard to your second case, would say that I can see no reason why the black stain shouldn't be removed. The cause of this stain is very hard to determine, except that it is probably due to an excess of sulphureted hydrogen. Why it causes a stain on teeth in certain cases I have never been able to determine. It seems that it should not be from the diet in your case, but it would be interesting to know if the mother is affected in a similar manner or if her metallic fillings oxidize quickly.—G. R. WARNER.

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*Editor Practical Hints:*

I have a peculiar case, and would be glad to get some information. Made a full lower plate for a man about 60 years of age. Teeth had been out about nine months. A few weeks after the patient had worn the plate neuritis of the right shoulder developed, and continued very painful for a while. He was advised to remove this plate and since

then he feels much better. Neuritis nearly all left. Can write and sleep without narcotics, which he formerly could not do. Patient also wears a full upper plate.

C. B. C.

ANSWER.—I think your plate is making a pressure upon the nerve trunk at the inferior dental foramin. You can, no doubt, locate this point by pressing with your finger or a large ball burnisher, or if not that way with an x-ray picture. After you have located the exact area on the gum, make pressure and see if you can produce the neuritis in the arm by so doing. If so, trim the plate off liberally in this area and all will no doubt be well.—V. C. SMEDLEY.

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*Editor Practical Hints:*

Enclosed please find two sets of x-rays on which I would like your advice.

No. 1. Patient male, twenty-eight years old. Upper left bicuspid extracted about two years ago, badly abscessed. While taking x-ray



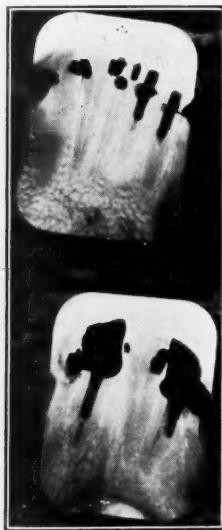
No. 1

to locate another condition this area was discovered. Do you think this is just a growth of new bone, or is it a Cyst, and what should be done to clear it up?

No. 2. Patient male, twenty-five years old. Complained of ear trouble and went to specialist who could find nothing wrong and ordered x-rays of the teeth which were all clear except enclosed two.

I have suggested removing crown and treating root to try to clear up the area, and if tooth does not respond to treatment to extract it.

Patient is very loath to have tooth treated, as it has never been



No. 2

sore, and another dentist told him that this shadow does not signify anything definite.

Would like to have your opinion very much, and any advice that you can give would be very greatly appreciated. L.M.G.

**ANSWER.**—Your case No. 1 shows some radiolucence of the bone where the first bicuspid was removed, but to my mind not enough to warrant operative interference. The maxillary sinus comes down pretty low in this area but I judge that you have no question about this being infected.

I notice decay on the distal of the cuspid in both radiograms and decay on the distal of the first molar and mesial of the second molar in the radiogram with the bridge in place.

Your case No. 2 shows radiolucent areas around lower left central, upper right lateral and left central. All three of these teeth are potential sources of systemic infection, and it is very doubtful if retreatment would change their status. The upper right lateral probably has a perforation of the distal aspect of the root which would be a contraindication for treating this root.

The upper left central shows the least destruction of periapical bone, but might yield a profuse growth of pathogenic organisms upon culturing.

The lower left central shows some destruction of the cementum and is an unfavorable tooth for root canal surgery under the most favorable conditions.—G. R. WARNER.

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*Editor Practical Hints:*

Patient, male, 62 years old, has complete upper and lower dentures.

Four months after completing same he complained of a pusy exudate gathering under the upper plate. He has kept dentures out for three or four days at a time and used a saline solution as a mouth wash, but condition still remains.

He, apparently, is in good physical condition, eats well and is quite active.

Would appreciate any help you can give me concerning etiology and treatment of this case. A. E. P.

ANSWER.—I should examine this mouth very carefully for a fistulous opening and also have the entire edentulous area radiographed. You will probably find a root end with suppurative area about it, an area of necrosed bone or something of the kind needing surgical correction.—V. C. SMEDLEY.

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*Editor Practical Hints:*

Could you give me any information concerning slides or movie films pertaining to dental interests? I have to give a talk to a group of children and thought I would like to obtain a film to impress upon the tots the necessity of a clean tooth. If such things are produced where could they be obtained? A. J. P.

ANSWER.—Miss Evelyn C. Schmidt, Director Department of Dental Health Education, 5 North Wabash Ave., Chicago, Illinois, will be able and glad to furnish you with all of the data and information that you will need.

This is a mighty worthwhile work, and it would be better if a great many more men were seeking this information for the same purpose that you are.

The Mouth Hygiene and Public Instruction Committee of the Colorado State Dental Association has tried out a good many of these things, and it is their opinion that the Tommy Tucker tooth film is the best movie on the subject that is available to date.—V. C. SMEDLEY.

*Editor Practical Hints:*

I gather from many things you say in your Digest Department that you know a very good remedy for Vincent's Angina. Would appreciate some information about this drug at your earliest convenience.

R. A. C.

ANSWER.—The preparation that we use for treatment of Vincent's Angina is not a proprietary article or drug, but the following prescription which we have filled at the drug store:

Peroxide of Hydrogen .....	10 oz.
Wine of Ipecac .....	6 drams.
Glycerine .....	10 drams.
Fowler's solution .....	10 drams.
Aqua Purae qs.....	16 oz.
M. et Sig.	

Use with a very strong spray. Give patient some for home use.

This is used in the atomizer with heavy air pressure once or twice daily until the most acute condition is overcome. It is then used on alternate days until the normal condition of the gums has returned. After the first acute condition is over the teeth are thoroughly scaled and polished. Positive results are obtained in most cases in twenty-four hours and in all cases not to exceed two or three days. The patient is given a bottle of this solution with instructions to wash the mouth with it three times daily until a cure is effected.—V. C. SMEDLEY.



## DENTAL SECRETARIES and ASSISTANTS

### Secretaries' Questionnaire

All questions and communications should be addressed to Elsie Pierce, care of THE DENTAL DIGEST, 220 West 42nd Street, New York City.

*In making a treatment the other day in which the doctor was using pure carbolic acid, the patient threw up her hand and caused the cotton dressing which was saturated with it to fly against her face. This was not noticed at once, but very soon she complained of a burning sensation and the spot became inflamed and it was realized what had happened. What should have been done to relieve this patient? Vaseline was applied, but that did not seem to help much.*

S. E., South Dakota.

A carbolic acid burn on the skin should be immediately washed freely with pure alcohol to neutralize the acid. Following this, the burn can be treated like any other burn, by saturating with olive or castor oil and covering with a sterile gauze dressing. Or a paste of starch, flour or baking soda can be applied to the burned surface. The object is to keep the air from the burned area. On the face such a dressing can be held in place by narrow strips of adhesive tape.

If you are called upon to take care of an extensive carbolic acid burn within the mouth, such as might be caused by taking a dose of medicine from the wrong bottle, symptoms of which would be indicated by the whitening of the mucous membrane if the acid is pure, and the darkening of the membrane if the acid is impure, your first concern should be to summon the nearest physician at once. Then give large doses of castor or olive oil or salad oil, raw eggs, milk, flour and water, or starch and water. This can be either laundry starch or corn starch. Epsom salts are also an antidote, two or three tablespoonfuls in water to a dose. If you have nothing else at hand, lime water may be used to rinse out the mouth and to drink.

In all the foregoing antidotes the exact quantity of each to be given is not nearly so important to know as to be sure to give enough of them —better give too much than too little. When carbolic acid has been

taken internally, there is usually severe vomiting, so that the use of an emetic is not the first consideration, but rather the soothing of the membranes and tissues that have been seared by the acid.

Here it may be well to give a word of caution as to the care which should be taken in the handling of dangerous medicinal preparations or chemicals. Too much attention cannot be paid to the proper labeling of the containers of such drugs. Specially shaped containers or bottles are safer than ordinary ones used. Containers of poisonous drugs and medicines should never be placed in the same cabinet or closet where harmless preparations are kept.

*Will you please tell me how to solder a two-piece crown and how to cast a gold inlay? In the office where I am employed the doctor has no books giving this instruction. I have not been a dental assistant very long, and I know I could help the doctor better if I knew how to do some of the laboratory work.*

F. H., Maryland.

Unless you possess a certain amount of technical skill in mechanics, it is impossible to describe the mechanical operations you speak of so that a beginner would be able to understand. While these things are quite simple of execution, a description of the technic used would no doubt be confusing to you.

My advice would be for you to join a class in laboratory work such as is given in your local dental assistants' society, or any other laboratory technic class where instruction along this line is given. Can you not interest your employer to teach you, or at least watch him carefully when he does this work, in this way familiarizing yourself with the details? No doubt you can borrow books on gold-casting technic from some other dental office if the dental society of your locality has no library. In fact you can secure such books of instruction from the manufacturers of casting machines and gold solders. However, I urge you to secure practical instruction, as this is really the best and quickest way to become proficient in any form of laboratory technic.

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## December Meeting

OF THE

EDUCATIONAL AND EFFICIENCY SOCIETY FOR DENTAL ASSISTANTS,  
FIRST DISTRICT, NEW YORK, INC.

The December meeting of the Educational and Efficiency Society for Dental Assistants, First District, New York, was held at the Academy of Medicine, 17 West 43d Street, New York City, on Tuesday, December 8, 1925. President Juliette A. Southard opened the

meeting, extending a welcome to all present, and then appointed Sylvia Danenbaum to act as chairman. This procedure was established last year in order that each member of the Society might have the opportunity to gain the poise, self-reliance and knowledge of parliamentary procedure which such an experience can bring.

The meeting was the occasion of the fourth birthday of the Society. During the four years just passed, its members have faithfully adhered to the ideals and aims of the organization, striving steadfastly to gain for themselves the educational advantages arising from association and cooperation with others engaged in a mutual work, to acquire a keener appreciation of the finer and broader aspects of their calling, and to establish a higher standard of education and training for the dental assistant in order to increase her efficiency in service to the dentist and his patients. The Society today is well organized and incorporated, fully recognized and affiliated with the American Dental Assistants Association, whose president is its own president.

The essayist of the evening was Dr. L. M. Waugh, who spoke on *Ethics*. There was also a speaker on *Investments*, Mr. F. G. Davison. Messages of congratulation and good wishes from Dr. George Wood Clapp and Dr. C. M. F. Egel were read. Dr. L. W. Dunham spoke a few words, and the First Honorary Member of the Society, Dr. Henry Fowler, brought a birthday message of encouragement and inspiration.

The various standing committees reported progress. The Clinic Club, Agnes F. MacNeill, acting director, reported the success of the clinic presented before the Mid-Winter Meeting of the First District Dental Society, New York, on December 4, 1925, at the Hotel Pennsylvania. A playlet depicting the contrast between the services of the incompetent dental assistant and those of the efficient dental assistant, enacted before the presentation of the clinic, was also enthusiastically received. Emily Campbell, director of classes, announced the formation of classes in model-pouring and x-ray assistance and asked that all members interested in joining these or any other classes as they are organized communicate with her at once at 339 East 139th Street, New York City. These new classes are in addition to the First Aid Class being held now each Thursday evening at the Red Cross Teaching Center, 345 Lexington Avenue, New York City, under the direction of Dr. M. Gregory. First Aid Certificates will be issued to members qualifying in the examinations to be given at the close of the course, which includes ten lessons.

A rapidly developing activity of the Society is the Library, containing books, magazines and papers of interest and value to the dental assistant in her work. These are in the care of the librarian, Anna Neulinger, who urges the members of the Society to take advantage of this opportunity to read the current dental literature and to aid the

Library to function. Miss Neulinger is also compiling a scrapbook in which she is placing clippings and articles relating to the duties of the dental assistant, methods of procedure, history of dentistry, dental equipment, etc. The librarian may be reached at 535 West 110th Street, New York City, or at any regular meeting of the Society.

The Society meets regularly at the Academy of Medicine, New York City, on the second Tuesday evening of each month, October to May, inclusive. At the February meeting the speakers will be Dr. Samuel G. Mischlin, who will speak on *What Is the Aim of Human Life and Is There a Philosophic Reason to Prolong It?* and Warren Hall, M.D., Ph.D., who will talk on *Dynamic Force*. A cordial invitation is extended to members of the dental profession and to their assistants.

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### Clinic Club

OF THE

EDUCATIONAL AND EFFICIENCY SOCIETY, FIRST DISTRICT, NEW YORK

The December meeting of the Educational and Efficiency Clinic Club took place on December 21, 1925, at the office of Dr. Williamson, 48 West 50th Street, New York City.

The work of the Laboratory Section was demonstrated by Jean Tallaksen. This section, which is one of the several that compose the clinic, explains the duties of the dental assistant in the laboratory, describing her work in the piecing and waxing together of plaster impressions, the pouring and separating of models, the building of bites, the setting-up of teeth, the investing and casting of gold inlays, and the construction of bridges. The clinician explained clearly the fundamental principles underlying this phase of dentistry and showed how the dental assistant may apply herself in order to be of greatest assistance in the laboratory. As is the usual procedure at the Clinic Club meetings, at the close of the short lecture the audience was accorded the opportunity to ask any questions which still remained unanswered in their minds and to offer suggestions for the further improvement of this particular section.

In addition to the Laboratory Assistance Division, the Secretarial, Chair Assistance and Instrument-Sharpening, Orthodontic Assistance, X-Ray Assistance, and Sterilization Sections compose the entire clinic and together present a definite picture of the regular duties of each assistant. The section on Secretarial Duties explains the executive branch of the calling—appointment making, telephone courtesy, book-keeping, filing, purchasing of supplies, etc. The other divisions explain the manual work of the dental assistant—assisting at the chair, aiding

in x-ray work, developing, mounting and filing of radiographs, methods of sterilization, laboratory duties, etc.

The members of the Club present clinics before meetings of dental societies and dental assistants' societies and demonstrate by means of these clinics the useful and competent services rendered the dentist and the patient by the trained, intelligent dental assistant in following her daily routine. At the regular meetings, on the third Monday evening of each month, the Club endeavors, through the demonstration of the different aspects of dental assisting and the interchange of ideas in general discussion, to increase the knowledge and skill of its members and to help solve the problems that are constantly confronting them in their daily work. The entire membership of the Educational and Efficiency Society for Dental Assistants, New York, is eligible to join the Club and to share in its activities, and is urged to do so.

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## A New Profession

By **Sylvia Danenbaum, New York, N. Y.**

There is a new profession for women in the offing. A few more years will see the calling of dental assistant metamorphosed into the profession of dental assisting, for the registered dental assistant is a certainty of the near future.

The laity of today are becoming more and more appreciative of the value of dental service. They are coming to the realization that the health of the mouth plays an important part in the general condition of the whole physical being and are giving more attention to the care of the teeth. The medical profession is cooperating with the dental profession to promote the prevention of disease and to educate the public to preventive dentistry rather than reparative dentistry. This new education and the incidental raising of the standards of dentistry demand the highest type of dental service, thus adding to the responsibility and cares of the dentist.

In order to meet his obligations in the proper manner, the dentist requires assistance, and from this new need has sprung the dental assistant of today. The patient in the office of the dentist demands the presence of a woman, as does the patient in the office of the physician. Her attendance in the office inspires confidence and often alleviates, to a great extent, the nervous strain which seems to be a necessary part of a visit to the dentist. The dental assistant is a teacher of preventive dentistry, especially to children; she is office manager as well as nurse, and as such she is of greatest value to her employer, because she conserves time—his one big asset.

Her duties are numerous and most interesting. As hostess in the office, she meets many types of people and soon becomes a student of human nature. As secretary and bookkeeper, she relieves the dentist of a large draft on his energy and time, releasing him for operative work. As guardian of the sterilizer, she assures the cleanliness and asepsis of the operating room and its equipment; in the laboratory she again saves time and expense; and at the chair, as the second right hand of the dentist, she has many opportunities for service through the exercise of her resourcefulness and intuition in anticipating the needs of the operator and in little attentions which add to the comfort of the patient.

To enter this form of service to humankind, the young woman must be versatile, and possess the acumen and initiative of the business woman, the gentle and soothing manner of the nurse, and the skilled and dexterous fingers of the artisan. For a number of years there has been some sort of assistant in dentistry, but not in the capacity in which she serves today. She entered as general maid and office girl, but in line with the march of progress she is today a valued asset in the dental office, a trained worker who is thoroughly capable of carrying responsibility and in whom can be reposed the utmost confidence by both the patient and the dentist.

At present there are no special college requirements to be met in taking up this work. At the first annual meeting of the American Dental Assistants Association, held at Louisville, Ky., in September, 1925, there was passed a resolution recommending that courses for the training of dental assistants be introduced into all the recognized dental schools of the country, and it met with the instant approval of the members of the Association and of the dental profession who had the opportunity to speak before the Association. This is, of course, a huge stride toward the goal for which every earnest, intelligent dental assistant is striving—the standardization of training for the assistant to the dentist and the establishing of this new profession of dental assisting. The present-day dental assistant is generally a high school graduate, oftentimes a trained nurse, and she is acquiring her education in dental procedure under the competent tuition of her employer and, by her own initiative, through educational organizations of forward-thinking dental assistants.

It is just such an organization which I have in mind. The Educational and Efficiency Society for Dental Assistants, First District, New York, Inc., is an organization devoted to the raising of the standard of education for the dental assistant in order to increase her efficiency and usefulness to the dental profession and to the laity. Its motto is *Greater Education for Greater Efficiency*. It is patterned after the dental societies and conducted according to parliamentary rules. There

is a regular meeting each month, at which there is a lecturer, usually a prominent member of the dental profession, who speaks on matters pertaining to the work of the assistant, and a woman speaker, who presents views of the world of women in general.

For the past four years the Educational and Efficiency Society for Dental Assistants, New York, has been conducting classes in the various phases of the work of the dental assistant, which have met with remarkable success. From a very inauspicious beginning—there were two classes attended by less than a third of the membership—they have progressed until now there is a list of classes offered that number ten, and there is scarcely a member of the Society who is not interested in at least one of them. Their arrangement and conduct form one of the principal activities of the Society. They are so planned that they do not conflict and do not affect the regular duties of the student except to increase her ambition and efficiency in performing them. Among the classes that have proved most popular in the past are:

Sterilization Class, where are taught the principles of the modern and most thorough methods of sterilization. Great stress is placed on the point that the first essential in the personality of the efficient dental assistant is an innate sense of cleanliness coupled with a sincere willingness to carry through, as far as is within her power, a cycle of asepsis in the dental office.

Class in Secretarial Duties, which emphasizes the most practicable and time-saving systems of bookkeeping, filing, etc.; lays the foundation of a complete understanding of office management; and explains the value of telephone courtesy.

Class in X-Ray Assistance, which covers the development and filing of radiographs, as well as the intelligent understanding of the reading of radiographs through a knowledge of the anatomy of the mouth.

Public Speaking and Parliamentary Procedure Class, which is one of illimitable value. There are taught the advantages to be derived from following a certain set arrangement of rules, of systematic procedure; and through practice in presenting short, original addresses before the members of the class and in debates on current topics, particularly those related to dental assistants, the students develop poise, self-confidence, resourcefulness, and the habit of logical thinking.

Class in General Laboratory Assistance, in which the student learns the fundamentals of mechanical dentistry; the piecing together of the plaster impression, the pouring and separating of models, the setting up and articulation of teeth, and gold inlay castings. Here it is that manual skill is developed and the young women learn to be of real assistance in the laboratory.

Class in Chair Assistance, where are taught the preparation of the various types of gauze and cotton swabs, the preparation of anesthetics,

the mixing of cements and amalgam, etc., and where the student is instructed how to render this assistance in a skillful and unobtrusive manner.

To these classes have been added classes in Care of Equipment, First Aid, Practical Psychology, and Porcelain Technic. It is in these courses conducted by the Society that the fundamentals are absorbed and the foundations of efficiency laid, to be built upon and elaborated by the individual according to her abilities and opportunities. The classes are free of charge to members and open to those in good standing.

Another splendid activity of the Society is the Clinic Club. This Club is composed of members of the Society and has as its purpose the representation of the different phases of dental assisting for efficient service to the dentist and patient and the proper conduct of the daily routine of the dental office. For the sake of expediency in demonstrating, the clinic is divided into several sections, but the whole comprises the routine duties of one assistant.

The Secretarial Section contains the various methods of bookkeeping, records, charts, filing, courtesy cards, telephone courtesy, and reception room courtesy.

The Section on General Chair Assistance and Accessories explains the care of the patient, first aid, the mixing of cements and alloys; the preparation for operative procedure, anesthesia, local and general; preparation of impression materials, plaster, modeling compound and wax; the making of accessories, such as gauze packs, wipes, sponges, etc., instrument wraps, glove wraps, bibs, aprons, and headrest covers.

The Sterilization Section demonstrates the thermal, therapeutic, and mechanical methods of sterilization, care of the handpieces and cutting edge instruments, care of general equipment, etc.

The Section on Orthodontic Assistance shows the preparation of models, bands, ligatures, etc., care of charts and records, sterilization and care of appliances, special plaster bibs, and special trays for drying impressions.

The Radiographic Assistance Section explains the preparation and care of solutions, the developing and mounting of radiographs, the filing of radiographs and keeping of records.

The Laboratory Assistance Section demonstrates the care of impressions, the pouring of casts in stone and plaster, separation and articulation, boxing, model carving and wax carving, setting up of teeth on wax base for trial, gold casting, and staining of teeth.

It is each member of a society such as this who is a pioneer of a great profession and who is blazing the way for her sister assistants who will follow with the years. Her progress in the last few years has been rapid; her work is approved and valued by the members of the dental profession and appreciated by the laity, but it is still just a

calling. A few more years will bring the registered dental assistant, aiding the dentist in his work of relieving the suffering of mankind and increasing the joy of living, and add another fine achievement to the record of women's work.

545 West 164th Street.



## EXTRACTIONS

No Literature can have a long continuance if not diversified with humor—ADDISON

Leather cushions are better. They are easier to clean after the garage man has "fixed" your car.

Striking miners are carrying the fire-prevention idea a bit too far.

(Teacher in Grammar Class)—Johnnie, please tell me what it is when I say, "I love, you love, he loves . . . ."

(Johnnie)—That's one of them there triangles where somebody gets shot!

It is often the case that the man who is "down" on a thing is found to be one who is not "up" on it.

Heaven bless us! Just a little while ago we were horrified by September Morn.

(Clerk)—How about a nice bathrobe for yourself?

(Countryman)—Nothin' doin', young man. When I take a bath I don't wear no clothes.

It used to be the cowcatcher; it's the carcatcher now.

(Little Willie's Prayer)—"Dear Lord give me the strength to brush my teeth every night, and if Thou canst not give me that strength, give me the strength not to worry about it."

A lady who had given a dinner party met her doctor in the street the following day, and stopped to speak to him.

"I am so sorry, doctor," she said, "that you were not able to come to my dinner party last night; it would have done you good to be there."

"It has already done me good," he replied tersely. "I have just prescribed for three of the guests."

The President went to church all by himself recently, and on his return the following dialogue with his wife took place:

(Mrs. Coolidge)—Was the sermon good?

(The President)—Yes.

(Mrs. Coolidge)—What was it about?

(The President)—Sin.

(Mrs. Coolidge) — What did the preacher say about it?

(The President)—He was against it.

The one nice thing about a certain kind of cheese is you can't tell when it is spoiled.

A woman will step into a booth, fix her garters, powder her nose, call up a couple of dead numbers, get her nickel back and come out much refreshed.

Why all this exaggeration about Chicago's crime wave! There must be several thousand people there not shot-yet.

### RULES OF THE ROAD IN JAPAN

At the rise of the hand of policeman, stop rapidly. Do not pass him by or otherwise disrespect him.

When a passenger of the foot hove in sight, tootle the horn trumpet to him melodiously at first. If he still obstructs your passage, tootle him with vigor, and express by word of the mouth the warning, "Hi, hi."

Beware of the wandering horse, that he shall not take fright as you pass him. Do not explode the exhaust box at him. Go soothingly by, or stop by the roadside till he pass away.

Give big space to the festive dog that make sport in the roadway. Avoid entanglement of dog with your spokewheels.

Go soothingly on the grease-mud, as there lurk the skid demon. Press the brake of the foot as you roll around the corners to save collapse and tie-up.

### ABOUT THIS TIME OF THE YEAR

While the year is young and blooming snow white virtue is the style; we have lately been entombing all our habits vain and vile; we have made our drastic pledges with their keen and cutting edges; on such vows no good man hedges—they must stand up for a while. All our neighbors, too, are moral, they have cut out that and this; with licentiousness they quarrel, they would live in spotless bliss; and we stand around debating topics high and elevating, and our virtuous orating they're unfortunate who miss. While the pledged ones stand together virtue never knows a slump, and there is no question whether erring mortal is a clump; but behold the break unbidden; one poor delegate has slidden, and another has ridden Pluto's pony to the dump. Then we sadly look around us as the year moves on apace, and the things we see confound us, they're discredit to the race; one by one our friends have rambled from the vows on which they gambled, and those vows are poached and scrambled, and the whole thing spells disgrace. We would keep our vows if only other gents would do the same, but it is an ordeal lonely, keeping up the stainless game, with no comrades near to brace us when the punk temptations face us and the corkscrew merchants chase us with their wares of sin and shame. So it is the same old story, to old habits we return; we forsake the path of glory, and our fierce cheroots we burn; for a while, from sin delivered, much of merit we diskivered, but the other fellows flattered, and their course we fail to spurn.—WALT MASON.

## DIETETICS and HEALTH

### The Value of Health

The desire to live long and well is instinctive. Self-preservation is the first law of nature and under its sway life lasts as long as the individual is capable of warding off accident and disease.

Primitive man knew little of personal hygiene and even less of general sanitation. He probably did not need them. He lived in the open, had plenty of fresh air and sunshine, and took ample exercise in seeking his food and evading his enemies. Barring sudden, violent death, the strongest survived—how long we do not know, but at least long enough to have progeny and transmit the qualities that made them survive.

With the beginning of community life, however, with its greater ease and comfort and the development of artificial surroundings, there came also the beginning of disease.

Disease germs which had been harmless up to this time now found favorable soil for growth in lowered resistance, favored by a lack of fresh air, the shutting out of the sunlight, the accumulation of filth, over-eating and under-nourishment.

With the dawn of history, says a writer in *Clinical Medicine*, the early recordings show that epidemics of contagious disease ravaged the communities, taking toll of millions of lives. Every man, woman and child was threatened by the dangers of disease against which they knew no protection.

Life was a game of chance against the menace of disease. The cause of contagion being unknown, superstition held the front in a fruitless fight against the horrors of disease that shortened the span of life to a point where the average person could not be secure beyond the beginning of adult life. The science of sanitation was not yet born to point out the truths that water and food may spread disease; that flies, rats and mosquitoes are disease bearers.

A scant half century ago, in 1876, Louis Pasteur startled the world by his discovery that germs cause disease. Here was the solution of the mystery of the origin of disease, and at the same moment was born the science of bacteriology, that not only was to shed light upon dark-

ness but to bring great material benefits and confer upon us longer life and greater health and happiness. With this momentous discovery, modern public hygiene was brought into existence to point the way to health, simply by living clean and wholesome lives. Superstition was destroyed by knowledge, and knowledge brought defensive action.

Concomitant with these discoveries there began a most significant and far-reaching movement, the awakening of the public conscience, and the general realization that health, far from being a mere individual matter, is a community problem. In other words, education in the facts of public hygiene and sanitation brought to light the danger of insanitary surroundings and stimulated activity that has almost banished several death-dealing diseases from the progressive communities. Education has taught the masses the secret of health and has made possible the mastery of surroundings and circumstances.

Besides the loss of life and the crippling effects of disease, the value of health to the economics of a community must not be discounted. Indeed, a nation is as rich as the health and vigor of its workers.

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## Psychoanalysis

The strife between the Freudian and non-Freudian groups continues, but with less noise than a few years ago. The contributions of Freud to our understanding of abnormal behavior are very generally accepted, though many refuse to follow him and his enthusiastic disciples in their more devious peregrinations in the subconscious. Certainly one who is accustomed to some introspection can not deny the relationship of many of his own dreams to the conflicts of his inner life. Psychoanalysis, however, is arduous and there are few who can perform its delicate operations upon the subconscious with skilled precision. In everyday practice, there seems to be a middle ground of mental therapy whereon many disorders can be righted, or at least ameliorated, by discussion of the patient's more or less conscious difficulties, together with instruction as to how he may face them and work out an honest solution of his problems.—*Exchange*.



## FUTURE EVENTS

The next meeting of the AMERICAN ASSOCIATION OF DENTAL SCHOOLS will be held at the Congress Hotel, Chicago, Ill., March 24, 25, 26, 1926.

DELOS L. HILL, *Secretary*,  
612 Grant Building, Atlanta, Ga.

The fifty-seventh annual meeting of the KENTUCKY STATE DENTAL ASSOCIATION will be held at the Seelbach Hotel, Louisville, April 5, 6, 7, 1926.

W. M. RANDALL, *Secretary*,  
1035 South Second St., Louisville, Ky.

The next meeting of the ALABAMA DENTAL ASSOCIATION will be held in Birmingham, Ala., April 5, 6, 7, 1926, with headquarters at the Tutweiler Hotel.

F. F. PERRY, *Secretary*.

The Fiftieth Annual Meeting of the VERMONT STATE DENTAL SOCIETY will be held at Burlington, Vermont, May 26, 27, 28, 1926.

LLOYD C. ROBINSON, *Secretary*,  
187 College St., Burlington, Vt.

THE NORTHEASTERN MASSACHUSETTS DENTAL SOCIETY will convene at the New Ocean House, Swampscott, Mass., on June 1-3, 1926.

HENRY I. YALE, *Secretary*,  
Peabody, Mass.

The annual meeting of the GEORGIA STATE DENTAL SOCIETY will be held in Savannah, Ga., June 9, 10, 11, 1926. All ethical practitioners are invited.

G. A. MITCHELL, *Secretary*,  
Candler Building, Atlanta, Ga.

At the meeting of the American Dental Association at Los Angeles in 1922, a movement was started by representatives of the Pacific Coast States to organize a triennial conference for the express purpose of developing clinicians and essayists on the Pacific Coast. The first meeting of the PACIFIC COAST DENTAL CONFERENCE will be held in Portland, Oregon, the week of June 21, 1926. It will be practically the only meeting of any size held on the Pacific Coast during the year.

J. CLARENCE JONES, *Secretary*,  
811 Broadway Bldg., Portland, Ore.

THE FIRST INTERNATIONAL ORTHODONTIC CONGRESS will be held in New York City at the Hotel Commodore, August 16-20, 1926.

Membership in the Congress consists of two classes:

*Regular Membership.* This membership can be had only through membership in component societies. It carries the right to vote and hold office. A payment of ten dollars (\$10.00) by a recognized Orthodontic Society with the endorsement of the plan of the Congress makes that society a component part of the Congress and its members regular members of the Congress and entitles the society to a bound copy of the Proceedings.

*Subscribing Membership.* This membership is open to all ethical members of the dental and medical professions, irrespective of their membership in the component societies. The dues for this membership shall be ten dollars (\$10.00) and shall entitle the member to all the privileges of the scientific session and a bound copy of the Proceedings. He shall have no right to vote or hold office unless he is a regular member.

It will be noticed that all members of the dental profession have the privilege of attending the Congress after becoming Subscribing Members.

In order that a Regular Member receive the bound copy of the Proceedings, it will be necessary for him to pay ten dollars (\$10.00), the same as a Subscribing Member.

The Orthodontic Congress is for the advancement of orthodontia as a science, and every member is allowed to take advantage of this meeting.

Membership blanks and further information may be obtained from Dr. William C. Fisher, President General, 501 Fifth Avenue, New York, or Dr. Walter H. Ellis, Secretary General, 397 Delaware Avenue, Buffalo, N. Y.

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The next meeting of the AMERICAN DENTAL ASSISTANTS ASSOCIATION will be held at the same time as the American Dental Association in Philadelphia, Pa., August 23-27, 1926.

JULIETTE A. SOUTHARD, *President*,  
174 West 96th Street, New York, N. Y.

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The next meeting of the AMERICAN DENTAL HYGIENISTS ASSOCIATION will be held in conjunction with the American Dental Association in Philadelphia, Pa., August 23-28, 1926.

Dental Hygienists make your plans now to attend this meeting.

LEONA M. MITCHELL, *Secretary*,  
State Department of Health,  
Harrisburg, Pa.

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THE DENTAL HYGIENISTS ASSOCIATION OF NEW YORK CITY holds its regular monthly meetings on the first Tuesday of each month, May to October, at the Academy of Medicine, 17 West 43d Street, New York City, at 8 p. m.

At each meeting interesting addresses and papers are presented by prominent members of the profession as well as by members of the Association.

A cordial invitation is extended to the members of the dental profession and dental hygienists to attend these meetings. Dental hygienists who are not members of the Association are urged to join.